C.D. Howe Institute

Benefactors Lecture, 2002

Canadian Health Care in a Global Context:

Diagnoses and Prescriptions

Åke Blomqvist

National University of Singapore
and
University of Western Ontario

Toronto, October 23, 2002

Sponsored by
Morneau Sobeco

C.D. Howe Institute

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Foreword

Canadians are now engaged in a critical debate about health care. With rising expenditures caused by the aging of the population, new technologies and higher compensation levels for providers, governments are looking at several options for improving health care services at reasonable cost. These options include introducing efficiencies, new approaches to health care delivery and new means to fund health care, either out-of-pocket or through new taxes and levies. Health care outlays are the most important expenditure made by provincial governments and it is not surprising that so many provinces have undertaken studies recently to evaluate the current system. At the federal level, several Senate committee reports have appeared and the much-anticipated Romanow report will soon be published.

The C.D. Howe Institute decided in 2000 to begin its own analysis of Canada's health care system. This Benefactors Lecture is a capstone to our efforts and provides an overview of the many critical issues faced by our current health care system. We asked one of the world's leading health economists, Professor Åke Blomqvist, of the University of Western Ontario, now head of the department of economics at the National University of Singapore, to undertake the difficult challenge of providing a roadmap for health care reform in Canada.

Professor Blomqvist has met that challenge. He first outlines several limitations to the current Canadian approach to health care delivery and funding. There is too much centralization of decision-making and too little separation of the functions of purchasing health care on the one hand and providing it on the other. The outcome is too little innovation, a lack of consumer choice and poor integration of services, such as hospital care, physician practices and drugs. He argues that the *Canada Health Act* and the rules for federal-provincial cost sharing are counterproductive because they confuse voters on the issue of who is responsible for various vital decisions.

Professor Blomqvist has provided a set of critical steps that Canada could take in order to meet its citizens' expectations for health services. He points out that, despite sharp differences in approaches, reforms in such countries as the Netherlands, Sweden, the United Kingdom and the United States are following a similar pattern, providing important lessons for Canada. Reforms that could apply to Canada include the decentralization of funding by splitting the responsibilities of purchasers from providers, the use of

rostering and capitation in primary care, competition among public plans, universal pharmacare and tax-based user fees.

The Institute's aim in presenting the Benefactors Lecture series is to raise the level of public debate on issues of national interest by presenting diverse points of view. In doing so, the Institute hopes to give Canadians much to think about, including information they need to exercise their responsibilities as citizens.

I wish to thank our Benefactor this year, Morneau Sobeco, and in particular William Morneau, President and Chief Executive Officer, for their generous support of this lecture.

The text of the lecture was copy edited by Lenore d'Anjou and prepared for publication by Kevin Doyle, Barry Norris and Marie Hubbs. As with all C.D. Howe Institute publications, the opinions expressed here are those of the author and do not necessarily represent the views of the Institute's members or Board of Directors.

Jack M. Mintz
President and Chief Executive Officer
C.D. Howe Institute

If we thought we were sure of anything about public opinion, it was that most Canadians think this country has a better health care system than the United States. But as any reader of recent newspapers must be aware, we are not uniformly happy about our system. As we increasingly have difficulty finding a family doctor, as waiting times to see a specialist or get an MRI become longer, and as more and more people go to the United States for certain kinds of treatment, Canadians are becoming increasingly critical of the health care system. At the same time, provincial politicians complain about its high cost, and some leading physicians leave the country to practise in better-equipped facilities in the United States. As the critical voices grow in number, some among them will, from time to time, ask the heretical question: would we do well to emulate some aspects of the US system?

In discussing health policy in recent years, I and others have taken a somewhat different line, arguing that Canadians tend to focus too much on the Canada-versus-US case. Because the US system has features that most Canadians find completely unacceptable, the conclusion drawn from these comparisons often is simply that, because our system is better, we have little to learn from south of the border. According to this view, more interesting lessons are likely to follow from comparisons between our system and those in a number of European countries where the objectives of health policy come closer to the universal and egalitarian ideals that underlie Canadian health policy.

In this lecture, I take an intermediate position in that I pay considerable attention to the possibility that recent US developments and policy initiatives may contain important lessons for Canadian health policy. Concrete, specific ideas for changes in Canada are probably most likely to come from European experience. However, many of the policies that have been adopted or debated recently in countries such as the United Kingdom, the Netherlands, and Sweden can ultimately be traced to ideas and principles central to the economic analysis of health care in the United States. To the extent that some of

I am indebted to Bill Robson for extensive suggestions and comments on successive versions of this lecture, and to Brian Ferguson, Colleen Flood, Grant Reuber, and John Richards for discussions about Canadian health policy over the years. Paul Boothe, Danielle Goldfarb, Jack Mintz, and Finn Poschmann commented on all or part of the manuscript. The lecture draws heavily on papers I wrote while spending a year as a visiting economist at the Applied Research and Analysis Division of Health Canada during 2000–01. While in Ottawa, I benefited from discussions with Cliff Halliwell, David Kelly, Senator Michael Kirby, Allan Pollock, and Sally Thornton. The exposition has been greatly improved by the firm yet tactful editorial hand of Lee d'Anjou.

Needless to say, the views that I express in the lecture are not necessarily shared by any of the above persons.

the most actively debated reform proposals are implemented in these European countries, their health care systems will, in some respects, become more like the US one. Conversely, although the early 1990s' attempt by the Clinton administration to create a government-organized universal health insurance plan in the United States failed, the reforms proposed at that time would have made the US system similar, in important respects, to those in some European countries. Thus, despite the seemingly large institutional differences among health care systems in North America and Europe, the same economic principles are at work. Understanding the forces that have led to changes in the US system is key to understanding the logic behind many European health care reforms.

The lecture is organized as follows: I conclude this introduction with a short preview of the main conclusions and proposals of the lecture as a whole. In the next main section, I summarize the strengths and weaknesses of the Canadian health care system, highlighting the problems caused by divided federal-provincial jurisdiction in the financing and governance of the system.

I then describe the US system, emphasizing the role of competition and choice in the market for health insurance and the way that feature may promote diversity and efficient institutional innovation in the system as a whole. In particular, it is the main reason for the emergence of *managed care* (plans under which insurers actively try to influence the type and the cost of the care their clients receive) as the dominant form of insurance and health services delivery in the United States today. I also discuss the fundamental shortcomings of an unregulated system of competing private insurance plans in attaining the basic goals of equity and efficiency. In this context, I consider the Medicare and Medicaid plans, through which the United States tries to remedy the worst equity effects of these shortcomings, and describe the main features of the Clinton plan.

In the next main section, I consider the experience that the Netherlands, the United Kingdom, and Sweden have had with health policy reform in recent years. Many of the ideas underlying the reform process in these countries can be related to the US system of competing insurance plans, especially those involving managed care, but with adaptations to suit the basic institutional framework of each country's existing health care system. A number of the approaches that have been used or discussed in these countries may be worth trying in the Canadian context.

Next, I provide a concrete set of proposals for reforming Canada's provincial health insurance plans and briefly consider what role the federal government could play in promoting such reform. I close by commenting on some longer-range issues, such as the implications of the rapid technological development taking place in health care today.

A Preview of My Main Proposals

The concrete proposals for reforming Canada's health care system that I make toward the end of this lecture flow from certain weaknesses in the system we currently use to fund and produce health services and from the way other countries have approached similar problems. The proposals relate to the following innovations.

Tax-based user fees. The qualifier *tax-based* means that patients would not pay fees when they receive services (visit a doctor or undergo an operation in hospital, for example). Rather, payment would be made through the income tax system. Before filing his or her income tax, an individual would receive information about the total value of health care services that he or she had used during the year. The patient's copayment would be computed based on this total.[1]

Regionalization and a purchaser-provider split. Canadians have long debated proposals for more decentralization in their health care and some provinces (Alberta, Saskatchewan) have created quite decentralized systems for managing their hospitals. The proposals I make go beyond the existing attempts in several respects. First, I propose that regional authorities be responsible not only for the hospital services in their jurisdiction but also for physician services (and possibly for drugs as well). Second, I argue in favour of a system in which each regional authority's budget would be determined in accordance with a *population-based funding formula*,[2] rather than on the basis of more or less *ad hoc* negotiations with the provincial government.

In several countries, decentralization of health care funding has been accompanied by a move toward a system referred to as a *purchaser-provider split*, and I believe the provinces should move in that direction. The underlying principle is that the governance of the health care system should clearly distinguish between the task of managing the institutions that produce health services (hospitals and physicians' practices) and that of deciding on what quantities of different health services should be produced.

Rostering and capitation in primary care. The issue of the most appropriate way of paying for the services of physicians has long been recognized as a central

1 For an account of the Canadian discussion of tax-based user fees in the mid-1970s, see Reuber (1980, chap 8).

2 Health care analysts use the term *population-based* because the formulas used for this purpose depend largely on a region's population.

one in the design of an efficient health services system. The fee-for-service method that predominates in Canada is used in many other countries, but other forms of physician remuneration have become more common in recent years, especially in the United States, where managed-care plans have moved increasingly toward alternative payment methods, such as *capitation* (under which doctors receive a fixed sum per enrolled patient over an agreed-on period, regardless of the quantity of services the patient uses). I strongly believe that introducing some form of at least partial capitation as a method of paying primary care physicians should be an important element in health services reform in Canada. (Such a method would have to be combined with *rostering*, a rule that restricts patients to seeking care from only one doctor — the one on whose list they appear — during the contract period.)

Several countries extend the capitation principle to items other than physicians' services that influence the total cost of a patient's health care, such as pharmaceuticals and certain kinds of elective hospital procedures. Under such a system, the United Kingdom made some doctors responsible not only for supplying the primary care services their patients need, but also for paying part of the cost of the pharmaceuticals they prescribe and of a range of elective hospital procedures a patient undergoes on their recommendation. Such a system clearly promotes more cost-effective patterns of care, and some version of it could be used in Canada.[3]

Choice among competing insurance plans. Many people in this country take great pride in the fact that all Canadians, rich and poor, are covered by the same publicly funded health insurance plan. But other things being equal, choice is a good thing and, on balance, I believe a strong case can be made for introducing some choice among different publicly funded insurance plans. Specifically, I argue that Canada could introduce the principle of capitation and rostering by offering individuals a choice between at least two alternative forms of publicly funded insurance, with doctors paid through capitation in one of the plans.

Universal pharmacare. Currently, the provisions of the *Canada Health Act* do not specify a public sector role in providing insurance that covers the cost of pharmaceuticals. All provinces do offer some degree of publicly funded insurance protection of this kind to some population groups, but most provincial plans are not universal. The lack of coverage for some people and the disadvantages of a system of mixed public/private coverage provide sufficient reason for expanding existing provincial plans so that they offer coverage on

3 In the United Kingdom, this system is referred to as *fundholding*.

a universal basis and for modifying the *Canada Health Act* in a way that would encourage this extension.[4]

Later, I discuss the experiences of several other countries on which my recommendations are based. I begin, however, with a brief description of the main strengths and weaknesses of Canada's system compared with those in other countries.

The Canadian System: Strengths and Weaknesses

Most Canadians agree that, in comparison to the US health care system, ours has the overwhelming advantage of providing, at least in principle, *universal* access to covered services (that is, acute care hospital and physicians' services). It does so with zero user charges and thus implicitly provides complete protection against the financial consequences associated with expenditures for such services in case of serious illness.[5]

However, the Canadian health care system also has weaknesses that have become increasingly apparent in recent years. To a believer in the benefits of competitive markets, an easy explanation is available: each province has only one health insurer — namely, the provincial government. That is, in this insurance market the government is a monopoly provider, and if most microeconomists agree on anything, it is that monopolies tend to be inefficient.

Because provincial health insurance monopolies are publicly owned, the problem with them is not that they charge high prices. But, in the memorable phrase of John Hicks, "[t]he best of all monopoly profits is a quiet life" (1935, 8). That is, the waste of resources associated with a monopoly market structure may come in the form of reduced productive efficiency and failure to make innovative use of the opportunities that new technological developments present. Such efficiency losses certainly may exist in publicly organized monopolies, which have no owners or shareholders to keep costs down in order to increase profits. Moreover, when managerial accountability is to politicians, not shareholders, there is the risk that the interests of producer

4 For the provinces to agree to such an extension of the act, they would clearly have to be given considerable freedom to design their pharmacare programs so that costs could be effectively contained through, for example, the use of patient copayments (which could be integrated with the tax-based user fees discussed above) or restrictions on what drugs would be covered.

5 For some people, a major potential consequence of serious illness is the subsequent inability to work and thus a loss of income. Although the federal and provincial governments have programs that at least partially replace workers' income in cases of work-related injury or illness, our publicly funded system of income replacement when a person becomes ill is much less comprehensive than that of many European countries.

groups with political clout (such as the unions or lobbying groups of doctors, nurses, and hospitals) may get more importance in decisionmaking than does the more diffuse public interest, a situation that may indirectly exacerbate the lack of incentive to undertake productivity-improving innovations.

To the extent that the weaknesses of a public monopoly system make the health care system less efficient than it otherwise could be, the consequence is either a higher cost or a lower standard. Until a few years ago, most Canadians were relatively satisfied with the standard of care they received, and the emphasis was on cost containment. The past several years have, however, seen a growing concern over declining standards. Increasing public attention has been paid to problems such as increasing waiting times for various types of surgery and consultations with specialists. One consequence has been queue-jumping by well-connected people, something that effectively amounts to a hidden and particularly distasteful version of two-tiered medicine, to use the popular phrase. In many places, an ordinary citizen encounters difficulty in getting access to a regular family doctor, and in a significant number of cases advanced diagnostic procedures and treatments that are readily available in the United States cannot be provided in Canada, so patients either go without or get them south of the border, sometimes at their own expense.

Is the Problem Underfunding?

The question of the best strategy for remedying these deficiencies remains controversial. Perhaps the most common response is that, essentially, the cause of the problems is a lack of resources. In the view of people who make this response, the current state of affairs is inefficient only in the sense that governments are not allocating enough aggregate resources to health care, given the population's willingness to pay for better care. Canada being Canada, commentators of course disagree about which level of government — federal or provincial — is most to blame, but many simply see increased health care spending by one or both levels as the most appropriate remedy. An alternative remedy would be increased reliance on some form of private funding, either through private insurance, which provides a significant part of health care funding in, for example, Australia and the Netherlands, or through the introduction of user fees, such as those in the US Medicare plan.

A different explanation of declining standards, however, is that the resources currently spent on health care are not used efficiently. For those who hold this view, the remedy includes not just an increase in aggregate spending but also the introduction of various kinds of reforms that would

improve the way health care resources are managed and allocated. I share this view, and most of the discussion in the paper deals with methods other countries have used to encourage more efficient use of existing resources.

To some extent, one can also justify user fees as a response to this problem. By giving consumers an incentive to use health services more conservatively, they may lead to improved efficiency. However, the decisions of consumers are not the only ones — perhaps not even the most important ones — that affect resource use in the sector. Thus, a large part of my discussion deals with reforms intended to strengthen the incentives for decisionmakers on the supply side of the system (doctors, hospital managers, and regional health authorities) to better manage the resources they control.

Centralization

Excessive centralization may be one manifestation of the lack of pressure on our monopoly insurance plans to be efficient. This problem may have arisen with the management of provincial hospital systems in the past. Even though the provinces do not own their acute care hospitals, the system of funding them through individually negotiated global budgets has, in effect, meant that the provincial governments have been directly involved not only in the allocation of funds among hospitals,but also in the budgetary process of each one. In part, this tendency may have existed because provincial politicians have found it advantageous to be involved in hospital funding. In many cases, decentralization would increase efficiency by reducing the number of layers of management, giving local decisionmakers increased flexibility.

Similarly, the monopoly position of provincial health insurance plans has led to a highly centralized system of determining remuneration levels and terms of employment for physicians, through bilateral bargaining between provincial governments on the one hand and provincial medical associations on the other.

Lack of Institutional Innovation

Another important consequence of the lack of competitive incentives in Canada's government health care monopolies is probably a decrease in the rate of innovation in the methods used to integrate the delivery of health insurance and health services in a cost-effective way. Insurance coverage is provided implicitly by provincial governments' simply paying, on behalf of patients, for insured services. There are no explicit restrictions on the individuals' choice of provider. Most providers continue to be paid in the same way they

have been for the past 30 years: physicians according to a negotiated fee-for-service schedule, and hospitals through global budgets negotiated with the ministry of health (or, in some provinces, its designated regional agency).

This state of affairs contrasts vividly with that in the United States, which has seen new systems of payment for services introduced at a rapid rate through the managed-care plans that now provide health insurance for a majority of Americans under age 65. Furthermore, new contractual arrangements between providers and insurers have been added, to a substantial extent, to the large publicly funded plans that cover the elderly and the poor, presumably in response to the demonstrated effectiveness of such arrangements in the private sector. Particularly in this area, institutional arrangements introduced in the United States have spilled over into the proposals for health policy reform in Europe.

Lack of Consumer Choice

A further possible consequence of a low degree of competitive pressure in a monopolized industry is a lack of incentives to develop products for a variety of consumer tastes. By and large, people appreciate a degree of choice in arranging their affairs; to some extent, this preference applies to health insurance as well. For example, individuals differ in their willingness to bear short-term risk. Thus, it is, at least in principle, efficient to allow them to choose among insurance plans that provide different degrees of protection. For example, people who are not strongly risk averse may, on average, be better off if they are allowed to choose a plan with a lower premium but a higher deductible (that is, during a year, they pay out of pocket for all their health expenditures up to a specified maximum). Accordingly, forcing everyone to sign up with a high-premium plan, with no deductibles or copayments, is not efficient.

Similarly, individuals and families may differ in their willingness to engage in behaviour that affects their risk of illness (for example, taking regular exercise and not smoking or drinking). Again, efficiency calls for a system in which individuals whose behaviour reduces risk to their health can be implicitly rewarded with access to lower-cost insurance, as may be possible in a system with many competing insurance plans.

Lack of Integration with Pharmaceuticals

Finally, technological developments in recent years have increased the potential payoff to closer integration between the decisions that govern the use of

pharmaceuticals on the one hand and physician and hospital services on the other. In a competitive system, insurers have an incentive to introduce plans that feature this kind of integration. But Canada's monopoly system offers little such integration, either because provincial insurance does not cover the cost of pharmaceuticals or because payment for them is through a plan other than the one for physician and hospital services. Other countries have at least some degree of integration, either because the publicly funded health insurance plan covers pharmaceuticals or because private plans do so.

Is the Problem Divided Jurisdiction?

On balance, I consider the current arrangement of divided federal-provincial jurisdiction one of the greatest weaknesses of Canada's health care system. It has had two very damaging consequences. First, it has led to the domination of the health care debate by what I view as an essentially meaningless squabble about whether or not the federal government is paying "its fair share" of the cost of health care.

Second, the eagerness of political parties to exploit the importance that the electorate assigns to health care has often led federal politicians to devote considerable energy to inventing imaginary threats to Medicare, so as to be able to present themselves and the *Canada Health Act* as the defenders of these principles. Too often, these "threats" have involved potentially helpful provincial measures intended to improve the cost effectiveness of the health care system (for example, introducing limited user fees and allowing private provision of certain services that are also offered by the public system). This pattern has weakened our ability to bring about meaningful change. As I have heard said in Ottawa, when it comes to health care reform, "our system of divided federal-provincial jurisdiction immobilizes us."

The CHST

The two pieces of legislation that give rise to this Canadian dilemma are, first, the one related to the Canada Health and Social Transfer (CHST), which governs federal transfers to the provinces for health care, and, second, the provisions of the *Canada Health Act* that stipulate the five conditions by which the provinces must abide in order to receive the federal transfer,[6] and the penalties if they do not.

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6 These conditions are that the plans must be "publicly administered," "comprehensive," "universally available on equal terms and conditions," "portable" (across provinces), and such as to guarantee "accessibility" to insured services.

The problem with the CHST is its name, which suggests that one can associate the transfers under this program with certain specific kinds of provincial spending. This idea is inherently meaningless, not only because the CHST is supposed to be for postsecondary education and social assistance as well as for health care but also because once funds have been transferred to a province under any program (the CHST, equalization, or any other), they become part of that provincial government's total resources. In the absence of political gamesmanship, a province's decisions on how to spend its total resources will be based on relative expenditure needs, not on whether the federal government has designated some parts of the total amounts transferred as being "for health," "for education," or for anything else. For this reason, the debate about what share of health care costs the federal government pays is a debate only about terminology and labels; it has no substance except insofar as the public is influenced by the mistaken belief that it does.[7]

Thoughtful people understand this. But in the inflamed Canadian debate about federal-provincial cost sharing, reason too often seems to yield to political posturing based on arbitrary numbers. As a result, attention is diverted from two issues that are much more deserving of serious debate: fiscal imbalance between the two levels of government (that is, whether total transfers to the provinces are reasonable, given the tax bases to which the respective governments have access); and provincial health system funding and governance.

I am a specialist in health economics, not an expert on the general issue of fiscal imbalance in a federal system, and therefore do not have much to say on the first issue. My impression, for what it is worth, is that since the provinces have responsibility for expenditure items, such as health and education, that are very large and that are growing as a share of gross domestic product (GDP), a larger share of total tax revenue does need to be channelled to them over time. One's view of whether this change should happen as a result of a trend toward lower federal taxation (perhaps through a transfer of income tax points to the provinces) or through increased federal transfers in part reflects one's preferences regarding how loose a federation we should have and in part one's analysis of the relative efficiency of federal and provincial governments in designing efficient tax systems. My own preferences lean

7 For afficionados, one big issue in the debate is whether the current value of certain income tax points that the federal government transferred to the provinces many years ago should be counted as part of the federal government's current share of the cost. (The concept of *tax points* refers to earlier federal-provincial agreements under which Ottawa reduced its income tax rates by a specified number of percentage points in provinces that did not wish to participate in certain federal-provincial shared-cost programs. Most of the tax points went to Quebec.)

in the direction of larger provincial autonomy (which makes me support either reduced federal taxation or *unconditional* per capita transfers to the provinces), but I also favour some amount of regional equalization.[8]

The *Canada Health Act*

In its current form, the *Canada Health Act* in my opinion has also come to be a counterproductive feature of the Canadian health policy debate for at least two reasons. One is lack of public understanding of the act itself. For example, when provincial health insurance was introduced, the requirement of *public administration* was put in the legislation in order to prevent the provinces from contracting out the administration of the new plan to the private health insurance plans then being marketed in Canada; it was not put in to rule out the plan's contracting with private providers (for-profit or otherwise) for the *production* of insured services. Yet today those who oppose such contracting often invoke this provision to support their position.

The second reason the current version of the act has become an obstacle to sensible health policy reform is that the interpretation of one of its central provisions, that guaranteeing reasonable access to insured services, is not considered on its merits as a health policy instrument but has come to be used as a symbol in the federal government's quest to profile itself as the defender of medicare.[9]

I find it difficult to believe that the accessibility provision was put into the act to prevent provinces from imposing health care user charges of any kind on anyone. In my opinion (and, according to a number of polls, that of many other Canadians), limited user fees would, on balance, be a good thing, and without the act some provinces would probably have them in some form. Under the act, they cannot. Ironically, the federal government's rigid position on user fees may have prevented it from playing a useful role in an area where it could have been doing so: encouraging or inducing provinces to introduce some form of universal pharmacare coverage. Ruling out any form of patient cost sharing is likely to greatly complicate the task of designing a pharmacare plan that would not break the bank.

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8 To some degree, it might make sense to allow this equalization to take place as a result of formulas that in part reflect relative expenditure needs (rather than measures of the provincial tax base, as at present). An example of this approach is Robson's recent proposal for a federal seniors health grant (see Robson 2001).

9 For example, in a highly politically charged conflict with Ontario in the 1980s, Ottawa insisted that any user fees different from zero were incompatible with the act's fundamental principles, and the act now incorporates a complete prohibition against user charges, together with rules specifying the penalties to which provinces are subject if they allow any.

Strengths and Weaknesses of the US System

As a background to my concrete reform proposals, I now turn to a brief comparison of Canada's health care system with those in several other countries, beginning with the United States.

Faced with an all-or-nothing choice, I would choose the Canadian system over the US one hands down. I would much rather live with what we now have in Canada, with all its faults, rather than accept the fundamental shortcomings of the US-style alternative. But I also think that the Canadian health care system is under more pressure today than it has been for a long time, and that it can be improved in ways that may make it more like the US system in some respects.

A perception widespread in Canada is that a major shortcoming of the US system is that it provides decent health care only for those who are wealthy enough to afford it. Yet, although some 30 million Americans have little or no health insurance, the United States does have major government programs that guarantee access to care for society's most vulnerable group. The federal Medicare program, which is publicly funded, covers all Americans age 65 and over. Moreover, all US states have Medicaid plans that cover individuals on social assistance and, more generally, those whose incomes fall below certain levels. Thus, although the public sector's share of health care funding in the United States (45 percent) is much smaller than it is in Canada (a little more than 70 percent), the difference is less dramatic than most Canadians think. Some people are surprised to learn that the Canadian percentage is considerably lower than the corresponding figure in such European countries as the United Kingdom and Sweden.[10]

Strengths

For Americans who can afford it, the US system offers health care of as high quality as anywhere in the world. On average, US doctors are extremely well trained, and hospitals throughout the country offer ready access to advanced technology. Indeed, more and more Canadians have been turning to US hospitals and clinics when their Canadian equivalents have long waiting lists or cannot offer certain kinds of treatment and equipment. In general, leading-edge medical technology of all kinds may be more available in the United States than anywhere else, simply because so much of the research and development (R&D) that produces it is carried out there.

10 This is the case even though both of these countries have parallel public and private health systems in the sense that private insurance may cover hospital and physician services paid for outside the public system, something Canadian provinces do not allow.

Coverage

Although some Americans who do not qualify for Medicare or Medicaid have no health insurance, most are covered by private plans. That is, their health care is paid for privately, but mostly through their insurance plans, not out of their own pockets. Thus, most Americans in this group have access to health care and are protected against the potentially ruinous financial consequences of serious illness, as Canadians are, except that this protection is through a private plan, not a government one.

A system in which a competitive market provides health insurance has serious weaknesses (see below), but it does have the advantage of offering some choice. For example, individuals may be able to choose a plan that reflects their preferred combination of cost and financial risk. Those who so desire can belong to a low-cost plan with high deductibles and copayments, while those who are unwilling to take risks can buy a high-cost plan with "first-dollar coverage." Similarly, some individuals may be willing to be covered by a relatively inexpensive plan that restricts their right to choose among doctors or that has rigid requirements for approval of certain kinds of expensive procedures.

To some extent, individuals' choices among insurance plans in a private system may reflect their incomes. For example, people with lower incomes may be more likely than those with higher incomes to accept low-cost plans with restrictions on their choice of providers. Again, conventional microeconomic reasoning suggests that, other things being equal, this situation is efficient; if individuals fully understand the consequences of their choices, artificially restricting them cannot be efficient.

Instinctively, many Canadians find this application of microeconomic reasoning distasteful. We take pride in the fact that we have a system in which, at least in principle, poor people and rich people receive exactly the same kind of health care when they are ill. Many probably see this attitude as a manifestation of Canadians' greater willingness to support the disadvantaged.

Yet what also applies here is the well-established principle that it is more efficient to support the poor through cash transfers than through transfers in kind. Given the choice, poor people as a group might well choose to accept a less costly system of health care (a lower standard of care when they are ill) in order to raise their consumption of other things (such as housing and food) when they are well. It may be, of course, that values other than efficiency come into play here. However, it seems to me that one ought to take seriously the idea that when we opt to support the poor in inefficient ways, the result may be a lower overall level of welfare for the poor than could be attained if the same amount of redistribution were made more efficiently.

And as more and more potentially expensive technology becomes available in health care, the aggregate cost of accepting this inefficiency may be growing over time.[11]

Insurance-Service Integration

Another important advantage of a system of competing insurance plans is the incentives it contains for innovative ways of integrating health insurance and health service delivery. The most important example of this is the managed-care revolution that has occurred in the United States over the past several decades.

Loosely speaking, *managed-care plans* are insurance plans that control costs by attempting to influence the cost and quantity of health services their members receive. (By contrast, in older forms of conventional insurance, a plan's only role was the passive one of paying the bills submitted by doctors and hospitals.) The attempts to control costs may include requiring patients to seek a second opinion before major surgery or to obtain approval from the plan before hospitalization. Other mechanisms involve restricting coverage to specific providers who have entered into direct contracts with the insurer. (Such contracts often specify that the providers will be paid through capitation or salary.)

Some decades ago, the most common form of managed care was insurance through membership in health maintenance organizations (HMOs), many of which pay their doctors via salary and treat patients in their own hospitals. In recent years, however, managed care through looser networks of providers has become more common. Recent statistics suggest that as many as 70 percent of Americans with private health insurance now belong to managed-care plans of some type (Glied 2000, 709), and some 40 percent of Medicaid enrollees are covered through such plans (Santerre and Neun 2000, 346).

The cost effectiveness of managed-care plans relative to conventional insurance remains controversial. The outcome of comparisons depends in

11 Although the logic here leads me to favour some degree of choice among more or less generous insurance plans, I nevertheless believe that, in a world where individuals differ in their risk of illness, public funding of at least basic health insurance can be a relatively efficient indirect way of redistributing real income. With a system of purely private health insurance, those individuals who can be identified as being at high risk of illness have to pay higher insurance premiums and thus effectively have a real income that is lower than those at lower risk. A system of publicly funded health insurance removes this source of income inequality. (For a formal model incorporating this idea, see Blomqvist and Horn 1984.)

part on the criteria used, since managed-care and conventional plans may differ not only in the average per capita cost of the health services used but also in the fees patients must pay and in different health outcomes. Early studies (such as the Rand study described below) clearly show that, without patient cost sharing through user fees, the per capita cost of managed-care plans could be as much as 30 percent lower than for a conventional plan, with little or no difference in health outcomes on average. However, almost all surviving conventional plans in the United States now have some degree of patient cost sharing. Given comparable populations, managed-care plans such as those offered by HMOs tend to have a cost advantage of perhaps 10 to 15 percent.[12]

Whether this number is a large or small one is, of course, debatable, but the fact that, over time, managed care has come to dominate the US market for health insurance suggests that it is a more efficient form, and that costs would have been even higher if conventional insurance had continued to dominate. The growth of managed care is particularly remarkable because the conventional insurance industry and others have had considerable success in getting US governments to engage in regulation that has made it harder for managed care to compete.

Weaknesses

The substantial potential advantages of relying on a system of private insurance for funding a major portion of health care are counterbalanced by a powerful set of disadvantages.

Administrative Costs

An obvious and well-documented disadvantage is the high administrative cost of a system of multiple payers. These costs are borne by insurers (in the form of premium billings, claims processing, and, in the case of managed-care plans, contract negotiations with providers) and also by doctors and hospitals, which have to deal with a large number of insurers in claiming payment for their services and in negotiating contracts with managed-care plans. Moreover, competition requires marketing, and the costs that insurers incur in selling their plans to consumers and employers correspond to a large

12 Glied (2000, 727–743) outlines the evidence on the cost effectiveness of managed care and provides a table summarizing most existing studies, as well as references. The figures cited in the text are from pp. 732 and 739, respectively.

proportion of their total costs of operation, thus raising the premium cost of their plans.[13]

Not all the expenses classified as the administrative costs of private insurance are wasteful, however. For example, some go to evaluating different kinds of technologies in order to assess their cost effectiveness. Another part is associated with developing new forms of insurance, such as managed-care plans. Resources spent on these kinds of activities are clearly not wasted.[14]

Adverse Selection

Another fundamental flaw of a system of private health insurance, from a Canadian perspective, stems from the fact that different individuals are subject to different risks of illness. In conventional economic analysis, most of the attention has been paid to the result that, under certain circumstances, risk differences may give rise to the serious efficiency problems associated with *adverse selection*. This phrase refers to situations in which individuals differ in their risk of illness in ways that insurers cannot easily observe but that are, however, known to the individuals themselves.[15] In such circumstances of asymmetric information, individuals who know themselves to be at high risk of illness will, other things being equal, be attracted to relatively generous insurance plans because they know that there is a relatively high probability they will need to claim benefits from the plan.

Because insurance relies on risk pooling, a plan's premiums reflect the expected claims of a person with average risk. For people with a low risk of illness, the premiums of a generous plan seem high, since they reflect the

13 The problem of high administration costs is likely to be particularly significant in the health care sector for two reasons. First, most transactions in other markets have only two parties, the seller and the buyer, while health care typically involves three parties: patients, providers, and insurers. Second, a large part of administrative costs in private health insurance markets goes toward identifying those who are at high risk of illness. This activity is, to a large extent, wasteful from an economy-wide point of view.

Markets for other types of insurance may share these characteristics to some extent. But in markets such as those for life and fire insurance, administrative costs are reduced by the fact that, although each claim may be large, the number of claims is small. Collision insurance for cars may be similar to health insurance in having relatively high administration costs, but the industry probably devotes fewer resources to identifying high-risk clients than private health insurers do (collision insurance is typically not offered as employment-based group insurance).

14 For a discussion of this issue in relation to the relative costs of Canadian and US health care, see Danzon (1992a; 1992b).

15 Insurance markets can break down completely in severe cases of adverse selection. See the classic paper by Rothschild and Stiglitz (1976).

expected benefits for low-risk people and high-risk people. The result is that low-risk people tend to seek out less-generous plans. But this preference is likely to further raise the premiums of generous plans, since those remaining in them disproportionately consist of individuals at high risk of illness. In the end, the generous plans may become so expensive that they disappear.

Such an outcome may be inferior to what prevails in a situation in which everyone belongs to the generous plan whose premium reflects the average risk for the population as a whole. That is, a more efficient outcome may be attained by forcing everyone to belong to a compulsory, publicly funded insurance plan in which risk pooling implicitly is carried out for the population as a whole, with those at low risk subsidizing those at high risk.

Job Lock

The preceding discussion implicitly assumes that private health insurance is purchased in the form of individual contracts between the insured person or family and the insurance plan. In reality, this is not the usual situation in the United States or in Canada for the private insurance contracts that cover many individuals for things such as pharmaceuticals. Instead, most insurance contracts are negotiated collectively between employers (acting on behalf of all their employees) and insurers. Implicitly, these group plans reduce the significance of adverse selection since they do not permit insurers to discriminate among employees with different risks.

This solution comes at a cost, however. The reason is that, while insurers generally must allow all existing employees in a firm to be part of the plan it negotiates with the employer, they are often allowed to refuse to enroll new employees. The result is reduced mobility in the US labour market. Workers who have been seriously ill are often forced to stay in jobs where they are covered by health insurance because they would not be eligible for the plans that cover the workers in the firms to which they might move. They also are generally unable to obtain individual coverage on reasonable terms. This effect is sometimes described as a *job lock* for high-risk individuals.

Distributional Inequity

Of even greater importance than the possibility of adverse selection and job lock is the fact that, given different illness risks, private insurance may give rise to serious problems of distributional inequity. Some determinants of risk of illness are difficult or costly for the insurer to observe, but others are not. One example of the latter type is age; older people have much higher expected

health care costs than young ones do. Other risk factors that may be observable, with some cost and effort, are based on the illness history of an individual's parents and siblings. Most important, insurers may have access to an individual's own illness history.

In a system of competing private insurance plans, insurers have an incentive to charge lower premiums to people with a low risk of illness and to charge those at high risk higher premiums or simply deny them insurance altogether. In a society that puts a high value on equity and fairness, such an outcome will not be considered acceptable.[16]

Once again, the inequity associated with different risk levels can be overcome by the simple expedient of forcing everyone to belong to a single publicly funded insurance plan that pools risk across the population as a whole. The desire to share equitably in paying for the cost of health care in this sense seems to me the most important reason that Canadians strongly support our system of publicly funded insurance and resist any suggestion that we move in the direction of greater reliance on private insurance.

The Clinton Plan

The discussion so far has identified certain strengths and flaws in the US system of competing insurance plans. An obvious question, therefore, is this: is it possible to design a health insurance system that avoids the disadvantages associated with adverse selection and the unfairness of discriminating according to risk of illness, but offers some degree of consumer choice and preserves the desirable incentives for innovation inherent in a pluralistic, competitive system? In attempting to answer this question, I briefly consider the ideas underlying the health care reform plan that President Bill Clinton attempted to introduce to the US system in 1993.

Although an incomplete version of this plan had figured prominently in Clinton's election campaign, the president was unable to get it through Congress. Nevertheless, it is worth examining — because it is interesting in itself, because some of its approaches are now incorporated in the US Medicare program, and because some of the extensive theory and analysis that were behind it have influenced health care reform in several European countries.

If the Clinton plan had been implemented, it would have provided Americans, for the first time, with universal access to adequate health insur-

16 It is important here to distinguish between risk differentials that are due to individuals' behaviour and lifestyle and those that are exogenous (such as age or parents' illness history). The fairness issue relates only to the latter. Few people would object to premium discrimination based on risk differentials arising from individuals' behaviour.

ance. It was also designed to preserve the principle of a pluralistic system of private health insurance that existed at the time.

The basis of the plan was a system of funding under which the cost of health insurance for each individual in a given region would have come from two sources: a transfer from a regional agency and a payment by the individual. The latter portion (which, on average, was supposed to cover some 20 percent of the premium cost) would have been the same for every individual enrolled in a given plan; insurers would not have been allowed to discriminate across people at different risks of illness. The transfer from the regional agency (the publicly funded portion of the premium) would, however, have differed among individuals according to recognized risk factors.[17] The purpose of this transfer system was, of course, to eliminate the insurer's incentive to discriminate against high-risk individuals.

The problems of adverse selection, job lock, and *cream skimming* (the incentive for insurance plan managers — and capitated doctors — to discourage the enrollment of individuals with high expected health care needs) would have been overcome by essentially forcing all insurance plans to accept all individuals in each region where they operated. Provided the transfer system was properly designed, this requirement would not have been particularly onerous. Although the expected cost to the insurer of covering individuals at high risk of illness would have been larger than for those at low risk, this differential would have been offset by the fact that insurers would have been paid a larger transfer from the regional agency for insuring them.

The pluralistic nature of the system would have been preserved by allowing insurers to offer different kinds of policies with different ranges of benefits, different restrictions on which providers the insured was allowed to obtain services from, different deductibles and copayments, and different private premium levels. However, each insurance plan would have had to obtain permission from the regional authority to operate in a given region; it would be granted only if the plan met minimum standards.

The Clinton plan was a remarkable piece of legislation. It represented a carefully constructed institutional framework for accomplishing the objective of finally providing Americans with universal access to health insurance, while preserving some of the major advantages of a pluralistic system offering medical care of high quality. Even so, the plan was defeated following an all-out onslaught by the private insurance industry and others with a vested

17 The exact specification of the rules that would be used to calculate these premium differences was not given, but they would have been based on the same kinds of criteria the private insurance industry currently uses for premium differentiation, including a person's age, sex, and perhaps previous history of illness.

interest in preserving the existing system. The campaign against the plan featured shameless exploitation of Americans' traditional suspicion of "big government." Nevertheless, the principle of consumers' having a choice among publicly funded insurance plans survives as an important element of the US health care system: within the federal Medicare plan that covers the elderly and some people with chronic illness, and, in some states, within the Medicaid plan.

The US Medicare Plan: Medicare+Choice

The US health care plan for seniors, which has existed for a long time, used to be called Medicare (and still is informally). When it expanded participants' options about a decade ago, the plan's name was formally changed to Medicare+Choice.

Technically, people eligible for the program can choose among three plans:

1. Plan A, the minimum plan, covers only hospital services. No monthly premium is charged, but consumers face some copayments.
2. Plan B covers doctors' services as well. Participants face copayment for those services as well as a regular premium, which is the same for everyone and administered as a deduction from the social security cheque that every American age 65 and over receives monthly.
3. Plan C is the managed-care option. Individuals can choose coverage under it by signing up with a managed-care plan that has been approved by the Health Care Financing Administration (HCFA), the authority that administers the Medicare plan. HCFA then transfers a monthly amount to the plan as a premium payment on behalf of the insured person. This amount essentially corresponds to 95 percent of the average expected cost of care under the traditional Medicare plan for a person of the same age living in the county where the insured person resides. In addition, the insured must pay part of the premium themselves, at a rate that may or may not be the same as the premium payment in the conventional Medicare plan B. The plan can set the premium at any level, but it has to be the same for every insured person (just as would have been the case for all insurers under the Clinton plan).

Together, plans A and B constitute the traditional Medicare system. They are based on the principle of conventional insurance under which doctors and hospitals are paid on a fee-for-service basis at negotiated rates. Because the premium is relatively low and most elderly people use the services of physicians regularly, few choose plan A only; the majority is insured through membership in both plans A and B.

In recent years, some 10 to 15 percent of the eligible population have chosen plan C. These individuals are subject to the choice-of-provider restrictions that apply under managed care. The incentive to accept these restrictions may be in the form of a personal premium that is lower than the one under Medicare plan B, or it may be lower copayments for physician or hospital services. More often, however, the incentive takes the form of the managed plan's offering a broader range of benefits than plan B. In particular, plan B does not cover prescription drugs; many of those who choose plan C do so in order to obtain that coverage.

The existence of copayments in Medicare has led to the emergence of so-called *medigap* plans, which are private insurance plans that typically cover the user fees that patients are responsible for under Medicare plans A and B. Increasingly, medigap plans are also providing coverage against the cost of pharmeceuticals. Thus, managed-care plans under plan C compete not only with the basic Medicare options but also with the private medigap plans.

Enrollment under the managed-care option grew rapidly during the mid-1990s but has decreased in the past few years, partly because plan costs have increased at a faster rate than the increases in the premiums payable by HCFA.[18] As a result, a number of managed-care organizations have stopped offering coverage under plan C. This tendency has been particularly pronounced in rural areas, where costs tend to be high and the ability of managed-care organizations to organize provider networks may be limited. Effectively, therefore, residents of urban areas have a greater variety of options for health insurance than do rural residents.

Lessons for Canada

Clearly, the most important lesson to be learned from observing the US system of health insurance and health services provision is a negative one: the provision of health insurance on a voluntary basis through a system of competitive markets is a very poor substitute for a well-designed, publicly funded and regulated universal system of insurance. The provision of health insurance through private markets scores badly in terms of commonly used ideas of equity and, because of adverse selection, is likely to give rise to major problems of efficiency as well. Significantly, among industrialized countries, the United States has the lowest share of total health care costs paid by the

18 Because conventional Medicare does not cover prescription drugs, the HCFA premium increases do not reflect the increased costs of pharmaceuticals, which have been powerful cost drivers in the North American health care system in recent years. (See HCFA 2000; Murray and Eppig 2002.)

public sector, and despite its relatively mediocre statistics on population health, it spends by far the largest amount of per capita resources (whether measured in absolute terms in purchasing-power-parity dollars or in relative terms, as a percentage of GDP) on health services. Any attempt at health services reform that relies on an enhanced role for competition and choice in health insurance must be made with awareness of the potential pitfalls of such a strategy, and the US example offers plenty of evidence.

The Advantages of Managed Care

The US experience also provides many positive lessons, however. A particularly important one is inherent in the outcome of the competition between conventional insurance and managed care. The evidence that managed care dominates conventional insurance is becoming more and more convincing. Of Americans covered by employer-sponsored health insurance, those with conventional coverage (that is, through plans that do not involve some form of managed care) have become a minority. Correspondingly, the case for experimenting with some type of managed care in Canada is, in my opinion, quite strong.

The Role of User Fees

Another potential lesson is that, in a competitive system, conventional insurance plans with no user charges do not survive. Existing conventional plans that do not involve managed care typically have such fees in the form of deductibles and copayments. This observation is consistent with the evidence generated by the carefully designed Rand Health Insurance Study, which was undertaken in the 1970s.[19]

The Rand study evidence is particularly compelling because it uses data from one of the few large-scale controlled experiments ever conducted in economics. The researchers found that subjects who had to pay the full cost of all their health services up to a predetermined limit (specified as the lesser of 5 to 15 percent of annual family income or $1,000 per year in late 1970s'

19 In this study, each subject in a sample of nearly 6,000 people was randomly assigned to one of several insurance plans, each with different kinds of deductibles and copayments. The researchers then compared the cost of care for individuals in the different plans over a three-to-five-year period; they also compared the health status of the subjects in the different plans during and after the experiment. The evidence from the Rand study is discussed at length in Newhouse and the Insurance Experiment Group (1993) and in Manning et al. (1987).

dollars) used some 30 to 35 percent fewer health services than those with zero user fees ("free care" in the Rand study terminology). Those who had to pay user fees equivalent to 25 percent of the cost of their care had utilization rates some 15 percent lower than those in the "free care" group. On average, these reductions in use did not appear to result in significant effects on patients' health status (although small and particularly vulnerable subgroups, such as low-income earners who had high blood pressure at the beginning of the study, did show evidence of worse health outcomes).

Interestingly, even though managed-care plans were not as common at the time the Rand study was undertaken as they are today, the study did include a comparison between conventional insurance and membership in an HMO. Although the managed-care plan used for comparison had no user fees, the use of health services for those covered by it was comparable to that of individuals covered by plans with substantial user fees. This finding, and the evidence subsequently generated by the competition between conventional and managed-care plans in the US market, imply a degree of substitutability between increased user fees and managed-care techniques in controlling health care costs. Given that managed-care plans typically expose consumers to less financial risk than plans with substantial user fees, my interpretation of this evidence is that, if a society can use only one of those tools, managed care is the preferred alternative. In principle, however, there is no reason the two techniques cannot be combined. That is, nothing prevents managed-care plans from requiring some degree of patient cost sharing through deductibles or co-insurance. Although not much evidence is yet available on the effect of doing so, preliminary studies suggest that the effect may be incremental — that is, managed-care plans with user fees do have somewhat lower aggregate costs of care than those without such cost sharing.

Different Types of Managed Care

Another potentially interesting lesson from the US experience concerns the relative attractiveness of different kinds of managed-care plans. The alternative included in the Rand study — insurance through membership in an HMO — is at one extreme of the spectrum of plans, in terms of both the restrictions imposed on patients' choice of providers and of the relation between the insurer and the doctors who treat the insured patients. In old-style "staff-model" HMOs, the doctors are employees of the plan, so it can exercise a high degree of control over the way they treat their patients. Moreover, coverage is often restricted to treatment by the HMO's doctors or in the hospitals it owns.

More recent times have seen the growing popularity of other kinds of plans, with somewhat less restrictive rules regarding choice of providers and with more independence between the insurance plans and the doctors treating the patients. For example, in *independent practice associations* (IPAs), the doctors who are responsible for patients' primary care are not plan employees but subcontractors, and may be paid on the basis of either fee-for-service or capitation. Also, many managed-care plans now allow patients to seek treatment from a provider who is not part of the plan, although, if they do so, they have to pay larger user fees than if they stay with the plan providers. The fact that these more flexible plans appear to be more successful than old-style HMOs may be relevant for the design of managed-care options in the context of a publicly funded system such as Canada's.

Managed Care and Publicly Funded Plans

Finally, of particular interest is the fact that managed care has been used in the publicly funded plans of Medicaid and Medicare, but typically as an option. That is, enrollment in managed-care plans has been offered as a choice for the eligible population rather than being compulsory. Whether these plans will become the dominant form of publicly funded health insurance in the future will, therefore, depend on the outcome of a process in which these different forms of insurance compete with each other for enrollees.

Some European Systems: Competition and Choice

Most European health care systems are more like Canada's than the United States' in that publicly funded or organized health insurance covers essentially the entire population. Yet European health care systems are organized in a variety of ways, differing from the Canadian model in important respects. Moreover, several European countries have undertaken, or at least actively discussed, major reforms that will or may increase competition and choice in the markets for both health insurance and health services and that use many of the same mechanisms underlying the system of competition among managed-care plans (and some conventional plans) in the United States. In this lecture, I discuss the reform approaches of the Netherlands, the United Kingdom, and Sweden, three countries whose health care systems I describe in some detail elsewhere.[20]

20 Blomqvist (2001a; 2001b). Each of these countries has a health care system that differs in important ways from Canada's. The United Kingdom uses capitation as a way of paying primary care providers; the Netherlands has a system in which some individuals may...

The Netherlands

Even before the reforms the Netherlands began to carry out over the past two decades, it, like Germany, had a health care system that differed from those in countries such as Canada, the United Kingdom, Italy, and Japan in that many citizens had the right essentially to substitute private insurance for public plan coverage. A substantial number of Dutch citizens elected to do so. Thus, even before the reforms, the health insurance market had a considerably higher degree of competition and choice in the Netherlands than in those other countries.

The Basic System

The Dutch have been engaged in reforming their health care system for almost two decades. But the changes originally planned have not yet been fully implemented. Thus, the easiest way to explain the country's system is to describe it as it existed in the early 1980s and then to examine the plans for reform.

In the Netherlands, every citizen is covered by a basic government plan that pays for certain "exceptional" medical expenses (including long-term care). Membership in this plan is compulsory. Most of the population is also covered by a public plan under which a statutory *sickness fund* pays for physician and hospital services and provides universal coverage for the cost of pharmaceuticals.

Traditionally, the sickness fund system has derived most of its revenue through a payroll tax collected as a flat percentage of income, up to a fixed earnings ceiling, and membership has been compulsory for all whose earnings are below that maximum. The system also receives certain subsidies from the government.

Before the reforms, the sickness funds were organized on a regional basis, so most employees had little choice about which fund they belonged to. This limitation was not important, however, because each fund offered the same kind of plan and collected revenue at the same proportional rate.

Before the mid-1980s, people with an income above the specified ceiling could choose either to pay the payroll tax and continue to receive health care

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Note 20 - cont'd.

choose to opt out of government insurance and substitute private coverage instead; Sweden's health system management and funding have been decentralized to elected regional representatives.

An excellent reference on health system organization and reform in the United Kingdom and the Netherlands is Flood (2000).

under the sickness fund system *or* instead to sign up with one of the many competing private health insurance plans. If they selected the latter option, they did not have to pay the payroll tax. That is, in Canadian terminology, individuals were allowed to opt out of the sickness fund plan and substitute private insurance. One of the early reform proposals was intended to further strengthen the role of private insurance by *requiring* citizens with earnings above the ceiling to leave the sickness fund system and rely on private insurance instead.[21]

When the Dutch reforms were being worked out, the market for private insurance exhibited some competition (in terms of coverage and premium levels), but it was not generally perceived as having had a favourable influence on the efficiency of the health care system as a whole. One reason was that the government heavily regulated the production of health services and, to a large extent, negotiated providers' terms of payment with a collective representing both the sickness funds and the private insurers. (That is, individual plans and providers had no separate contracts, as they do under managed care.) Moreover, premiums for private insurance were individually risk rated, so the usual problems of adverse selection arose. Because the Netherlands is a relatively egalitarian society with a highly developed set of welfare-state programs, the unfairness of a risk-rated system of private premiums was also a concern.

The Dekker-Simmons Reforms

The Dutch health care system, with its mix of regulation and competition between private and public insurance, was generally regarded as relatively inefficient, and a reform process started in the mid-1980s. The changes, which are not yet fully in place, are often referred to locally as the Dekker-Simmons reforms, after the chairs of the commissions that designed the detailed plans.

The Dekker-Simmons proposals aim at a dramatic change in the role of private insurance. In particular, the distinction between private insurance and insurance through the sickness funds would essentially disappear. The proposal also involves a shift to a system in which both sickness funds and private insurers would become much more like managed-care plans, similar in many ways to those existing in the US system. However, the government

21 By the early 1990s, as much as 30 percent of the population was covered by a private plan. Partly as a result of the role of private insurance, the public share of total health care costs in the Netherlands is only about 70 percent — about the same as in Canada but considerably lower than in countries such as the United Kingdom and Sweden — even though the public plan's coverage is broader than in Canada (OECD 2000).

would pay most of the plan premiums. Risk discrimination was supposed to end, as every Dutch citizen would be guaranteed access to every plan at the same out-of-pocket premium.

Comparing the design of the Dekker-Simmons reforms in the Netherlands with that of the Clinton plan reveals striking similarities. Indeed, if the Dutch plans were implemented in their entirety, that country's system of health insurance and health care delivery would function essentially in the way the Clinton plan envisaged. One reason for this similarity, one suspects, is that much of the economic theory behind both plans was influenced by the published work and advice of prominent health economist Alain Enthoven.[22]

The Dekker-Simmons proposals involve a system in which each competing insurance plan would obtain revenue from two sources: a government subsidy and a premium paid by the individuals the plan insures. The amount of the latter would be the same for all individuals in a given plan (though it could differ among plans), but the government portion would be adjusted for factors such as age, sex, and other determinants of the risk of illness and differences in the expected cost of care. Insurers would not be allowed to refuse any individual's application for enrollment in a given plan. Insured individuals' choice of provider would be restricted by the provisions of the plan they chose. Plans would enter into contracts with providers regarding the terms on which they would deliver care to insured clients and at what cost. In short, the Dekker-Simmons proposals involve a system of managed competition between rival managed-care plans, exactly as under the Clinton plan.

An important feature of the Dekker-Simmons plan is that its implementation is expected to happen largely through competition among insurers, with government regulation greatly reduced. The government's role would be limited to enforcing a few simple rules. First, every plan would have to have benefits that met minimum requirements specified by the government. Second, as noted, although each plan could set its own out-of-pocket premium for consumers, it could not discriminate among them, either by requiring different premiums for different individuals or by refusing to enroll particular patients. However, the government is not supposed to regulate the contracts that plans enter into with doctors and hospitals or their terms of payment; the assumption is that efficient contractual arrangements will emerge as a result of competition among insurance plans.

22 Although Enthoven has carried out most of his analytical work in health economics in the United States, he is of Dutch origin and has been much involved in advising European governments on the subject of health reform. He stresses the ideas of managed care and managed (regulated) competition among multiple insurance plans. (See Flood 2000, 70; Enthoven 1991.)

Because political constraints on the process of reform have been so severe in the Netherlands,[23] the Dekker-Simmons proposals have, so far, been only partially implemented. The distinction between private plans and sickness fund insurance has not yet been abolished. The former still finance their operations on the basis of risk-adjusted individual premiums, while the latter continue to rely on the payroll tax and government subsidies. The earnings limit that restricts patients' right to opt for private insurance is still in force. However, the sickness fund plans have recently begun to function more like competing managed-care plans and have started the process of selective contracting with providers about the terms on which services will be provided to their clients.

The United Kingdom

In contrast to the slow and fitful implementation of health care reform in the Netherlands, the United Kingdom has taken important steps toward a system that in some respects resembles one in which there is managed competition among managed-care plans. At first glance, the reform processes in the two countries look quite different, in part because their systems started with very different institutional arrangements. On closer inspection, however, one can recognize the elements of managed competition and managed care in the UK reform process as well.

The Background to Reform

Contrary to the case in the Netherlands, where hospitals are independently owned, all hospitals in the United Kingdom were owned and managed, as a single system, by the National Health Service (NHS) from 1948 until the beginning of the reforms proposed and partially implemented starting in the early 1980s. Hospitals received all their resources from the government in an annual negotiated budget process, and all specialists working in the hospitals as well as their administrators, were NHS employees.

Since 1948, primary care in the United Kingdom has been organized through a system of general practitioners (GPs) who are paid partly by salary, partly by capitation. To receive services through the NHS, each UK citizen

23 According to Schut and Hermans (1997), health system reform in the Netherlands is difficult in the face of the strong position of interest groups (such as those representing private insurers and health providers); this strength can be ascribed to the fact that the country typically is governed by coalition governments with limited ability to act decisively against the interest groups.

must register with a single GP who has a *gate-keeping* function (whereby access to prescription drugs, as well as to specialist and hospital services, is only through prescription or referral by the patient's GP). The capitation component of the doctor's monthly income depends only on the number of patients (with some weighting by age and sex) on his or her list, not on the volume of services he or she actually renders to each patient. Patients have the right to choose which GP they register with, but can do so only at particular times during the year. The government indirectly controls the number of capitated GPs, since they can set up in practice only if they have a contract with the relevant NHS agency.

Before the reforms, the NHS was a huge organization, exceedingly complicated to administer, and, being centrally controlled, open to a high degree of political interference. Because it imposed almost no user fees, the public widely appreciated it, and it did deliver basic care at relatively low cost.[24] Yet there were always complaints about certain aspects of the quality of care. For example, waiting lists for elective surgery were sometimes lengthy, and some patients had to wait a long time to be seen by their GPs.

Private insurance is also present in the UK health services system, even though its role is quantitatively less than in the Netherlands. The public sector share of total health care costs, at approximately 85 percent, is considerably higher than in either Canada or the Netherlands. Another reason for the discrepancy is that NHS coverage is very broad, including both pharmaceuticals and some dental and vision care, in addition to the traditional hospital and physician services.

As in Canada, private coverage consists partially of plans that pay for certain relatively minor services that the NHS does not cover. However, the bulk of private insurance is used to pay for physician services (and, to some extent, hospital services) outside the NHS plan. Private care is produced both by physicians who practise entirely in the private sector and by specialist doctors, who are allowed to practise partly in the private sector, partly in the NHS. People who decide to obtain private insurance are not relieved of any part of their tax bill (as the privately insured are in the Netherlands, in that those who have opted out of the sickness fund system are exempt from the payroll tax). Despite the lack of a financial incentive, however, as many as 10 percent of UK citizens have some degree of private coverage.

The co-existence of privately produced care alongside the NHS has long been a sensitive and controversial point in the United Kingdom. The correla-

24 On average, the share of total GDP that the United Kingdom devotes to health care has been considerably lower than that of other European countries and, of course, much lower than that of the United States.

tion between income and the use of privately produced care is doubtlessly high, as one would expect in a system in which those who use private care must have either sufficient means to pay for it out of their own pockets or enough income to pay for private insurance even though they have already paid for NHS care through the tax system. To some extent, one can perhaps explain the use of private care by the willingness of the well-to-do to pay for care in more pleasant surroundings, such as private hospital wards or the offices of privately practising doctors. Commentators often allege, however, that many people are willing to pay for privately produced care because they perceive it to be of higher quality in the sense of promising a better health outcome. In particular, it represents a way of getting around the problem of having to wait for certain kinds of specialist consultations or elective surgical procedures,[25] and long waits certainly must be considered a negative factor in the quality of care. As a result, the term *two-tier medicine* is in common use to describe the pattern of care in the United Kingdom.

The Thatcher Reforms

The major reforms of the UK health care system over the past few decades largely originated with the coming to power of Margaret Thatcher's Conservative government in 1979. Although it implemented some legislative provisions designed to strengthen the role of private insurance, they were minor compared with the changes made to the governance of the NHS. As discussed further below, the reforms involved a greatly enhanced role for incentives and competition, but they did so within the context of the publicly owned and funded system. That is, the Thatcher reforms largely involved managed competition in *internal markets* (where the agents competing with one another are publicly owned or compete with each other for government funds).

The reforms proposed in 1979 and 1980 were intended to accomplish several major objectives:

- Streamlining the administration of the NHS by extensively decentralizing it to the regional level. This objective was accomplished. However, the reforms were also supposed to bring about some equalization of health resources across regions through population-based funding, under which the share of total health care resources that a given district health authority (DHA) received would be based on a formula reflecting the region's population (adjusted for age and certain other factors). This change was only partially implemented, however, and actual allocations depend partly on the historical pattern.

25 For an extensive discussion, see Keen, Light, and Mays (2001).

- Bringing about greater reliance on competition and market-like arrangements inside each region. The government introduced what it refers to as the principle of a *purchaser-provider split*, under which the district authority plays a much-reduced role in actually managing the hospitals and other institutions that produce health services for the region's population. Instead, the DHA's role is that of a "prudent purchaser" of health care. It is an agency that negotiates contracts with hospitals about what services they provide and the basis on which they are paid. Accordingly, individual hospitals have received greater freedom to manage their own affairs, including the authority to negotiate separate employment contracts with their personnel. Hospitals are also responsible for ensuring that they stay within their budgets, with no assurance that the regional authority will automatically cover any deficits. If one views the funding agencies as buyers of care (on behalf of their populations), the providers are the sellers, and the reform designers expected some degree of price and quality competition among hospitals to emerge as part of the funding process. To strengthen the competitive element, districts are not required to award contracts only to local hospitals; if a seller in another district can provide certain types of care more economically, a DHA can choose this provider even if doing so means reducing the budget of a local hospital.
- Containing the cost of GP-controlled services through *fundholding*. GPs who became fundholders received additional capitation amounts for their patients. In return, the fundholders became responsible for a certain percentage of the costs their patients incurred for things such as pharmaceuticals and some types of elective hospital services. Although the GPs could not pocket any surplus that they managed to generate, they were allowed to invest it in improving their practice facilities. Conversely, they were responsible for paying a portion of any deficit out of their own pockets. An additional element of the scheme was that fundholding GPs were authorized to negotiate with the hospitals to which they referred their patients about the terms of the provision of the services covered by the fundholding.[26]

26 The services of primary care providers, on the one hand, and specialist and hospital services and pharmaceuticals, on the other, can be seen as different factors of production (inputs) used to produce the ultimate output of the health services sector — namely good health. From a theoretical perspective, one can view the fundholding idea as a response to the possibility of some substitutability among these different inputs. When it exists, some agent in the system should have an incentive to combine these inputs in as cost-effective a way as possible. A fundholding GP is such an agent and has such an incentive. (I come back to this idea in the conclusion of this lecture, in the context both of a program that ...

At first glance, it is not clear that the principles that were part of the Thatcher reforms are related to the ideas of managed competition and managed care. In certain important respects, however, they are similar.

First, when the administration of regional health care systems incorporates a purchaser-provider split, the role of the funding agency becomes similar to that of a managed-care insurance plan that contracts with providers to deliver care to their members. Indeed, when the regional health authorities in the United Kingdom both funded and administered their own hospitals, they were in a position similar to that of a fuil-service HMO in the United States that operates its own hospitals and employs its own doctors. With the introduction of a purchaser-provider split, the funding agency's role became more like that of a plan with a *preferred provider network* (a managed-care organization that offers enrollees a choice of obtaining care from any of several participating physicians on its list). Such networks have been growing faster than HMOs in the United States in recent decades, suggesting that they may derive a competitive advantage from encouraging competition for contracts with the insurer (as the UK planners envisaged).

A regional funding agency is, of course, a monopoly plan: Residents of a UK region have no choice of plans, as they would in the United States or the Netherlands. But even with a monopoly plan, it is possible and likely that the competition among providers for regional contracts can have beneficial efficiency effects.

The fundholding scheme can also be viewed as similar to a limited form of managed competition among plans, in the sense that each fundholding GP can be considered a separate plan that patients can choose. Moreover, since these GPs have the authority to negotiate with hospitals about terms for the provision of elective surgery, they are operating like a type of managed-care plan. In both respects, the key element is the increased use of competition as an efficiency-inducing device. The aim of the purchaser-provider split is more competition among providers for contracts. The fundholding scheme is premised on competition among fundholding doctors for patients. It also provides doctors with an incentive, when deciding on the pattern of treatment for a given patient, to take into account not just what services they themselves provide but also the cost of drugs and elective hospital services.[27]

Note 26 - cont'd.

...integrates pharmaceuticals into provincial health insurance plans and of the idea that regional health authorities in a decentralized system should be responsible for the cost not only of hospital services but also physician services and pharmaceuticals.)

27 The possible problem of cream skimming was much debated in the context of fundholding in the United Kingdom. In particular, analysts discussed the possibility of reducing the incentive to cream skim by making the capitation amounts that doctors receive depend...

The New Labour Government

When a Labour government under Tony Blair came to power in 1997, it abandoned some elements of the Thatcher reforms and remodelled others. For political reasons, the new government represented these modifications as a considerable change in direction for the system, but one can regard them as a consolidation and fine tuning of the older reforms, albeit under different names.[28]

An important element of the Blair government's approach is that the system of individual fundholding GPs is supposed to be replaced by one in which larger groups of doctors practise together. These groups will receive funding from the government in proportion to the number of patients listed with them. The scope of the fundholding system will be considerably expanded in that the group practices, rather than the purchasing agency, will negotiate with hospitals and other non-physician providers the terms on which patients will receive their services. Indeed, the intention appears to be that the purchasing role of the DHAs will be abolished, and the responsibility be given to the group practices instead.

It is still too early to tell much about how the revamped system will ultimately work in practice.[29] Interestingly, it appears that, to a large extent, the GP group practices will function like the managed-care plans in the Dutch system or as they would have functioned in the United States under the Clinton plan. Like comprehensive managed-care plans, they will receive risk-adjusted capitation payments from the government for enrolled individuals, and they will be responsible for paying for the pharmaceuticals their patients use and for negotiating terms with hospitals for the provision of in-patient services for their enrollees.

Note 27 - cont'd.

...not only on obvious factors, such as age and sex, but also on verifiable patient characteristics that would influence expected care needs, such as prior illness history, the presence of chronic conditions, and so on. See, for example, Matsagannis and Glennerster (1994).

28 Flood gives a good description of the changes being introduced and says that "the extent to which the logic of internal markets has truly been eliminated by the New Labour reforms is questionable" (2000, 103).

29 The process of transforming the system in accord with New Labour's reform plans has been a gradual one. By 1999, each GP practice formally belonged to a primary care group, but these groups did not yet have major fundholding responsibility. The process of transforming the primary care groups into primary care trusts (PCTs), which will have more responsibility, is not scheduled to be complete until 2004, by which time "PCTs will have responsibility for at least 75% of the NHS budget" (United Kingdom 2002). In 1997 under the old fundholding system, the corresponding figure was just 15 percent.

One might argue that some differences are important. For example, unlike managed-care plans in the Netherlands and the United States, the GP practices in the United Kingdom will be funded entirely by the government, with no consumer premium, so they will compete for enrollees solely on the basis of the perceived quality of their services, not through differences in premiums. Also, the amounts that GP practices receive through fundholding will be sufficient only to cover a share of the cost of drugs and hospital services, whereas a managed-care plan would pay the whole cost.

However, although the practical details may differ, the fundamental principle of managed competition among managed-care plans will nevertheless characterize the revamped UK system. Cost-efficient patterns of care will be promoted by competition among GP groups as they strive to be successful by raising the quality of the services they offer and negotiate cost-efficient contracts with other providers.

Sweden

Although Sweden has gone through a process of relatively significant health care reform in the past ten years, its system cannot yet be characterized as involving managed competition among alternative insurance plans. Essentially, the country has regional monopoly plans, similar to those in the United Kingdom, but it has made no major move in the direction of a universal system of fundholding in primary care. Nevertheless, it has recently introduced new elements that involve competition and incentives in the health care system.

The Swedish experience is interesting in other ways as well. Sweden is a relatively small country: with a population of about 9 million, it is smaller than the province of Ontario. Despite its size, it has a highly decentralized health care system, in which county councils play the most important role. On average, each council serves a population of no more than about 350,000. There is, however, great variation: the largest one, the city of Stockholm, has a population of 1.6 million. There is also considerable variety in the way health care is organized across the counties, particularly between the systems in the major cities and those in the more remote, thinly populated areas in the north.

The cost of health care in Sweden is borne jointly by the county councils and the central government. Before the reforms of the 1990s, the central government contribution included both transfers to the county councils and payment for certain components of the system, such as pharmaceuticals, dental care, and the services of privately practising doctors. Over the years, however, Sweden has moved away from direct central government payment for services, and responsibility for almost all health care, including privately

practising doctors and pharmaceuticals, now falls on the county councils. Thus, they are much like insurers charged with designing comprehensive health insurance packages for particular populations.

Currently, the central government's contribution to funding is almost entirely in the form of transfers. The amount of each transfer is formula based; essentially, it is proportional to the county's population, adjusted for factors (such as age structure and density) that can be expected to influence both the need for and cost of health care. Most of the cost of care, however, is borne by the county councils themselves.

The main component of the revenue sharing among Sweden's three levels of government — central, county, and municipal — consists in each level's having access to the income tax base. Once taxable income has been determined for an individual, he or she pays a flat percentage to the municipality and another percentage to the county. The third component is the central government income tax, which is collected at a progressive rate. Because health care accounts for a very large part of the expenditure responsibilities of the county councils, the income tax they collect comes close to being an earmarked health care tax.

Ultimately, the responsibility for decisions regarding health care and the rate of county council income tax rests with county political representatives, who are elected every four years. Thus, despite the lack of competition in the sense of individuals' having a choice among competing plans, the politicians responsible for organizing health care in each county are accountable to citizens for most of the cost in a highly visible manner. (The principle of specific elected representatives with responsibility for the health care system may be an interesting alternative to competing insurance plans, as most Canadian provinces continue to delegate health care decisionmaking more and more to the local level.)

Some national legislation regarding health care in Sweden is fairly broad — for example, county councils are required to provide "good health and care on equal terms for the entire population." Other laws deal with specific issues that have been important in the country's health policy debate at various times, such as maximum waiting times to see a primary care doctor or a specialist and the right of patients to choose a specific family doctor. Within the scope of these laws, county councils have considerable freedom to organize the delivery of care as they see fit.

National legislation also deals with patient copayments. The levels of user fees, which are set by the county councils, are fairly hefty, amounting in Canadian funds to some $15 to 20 for a visit to a primary care doctor (perhaps twice that for a visit to a specialist), and some $12 per day for hospital stays. Patients must also pay a substantial share of the cost of pharmaceuticals.

However, the national legislation contains relatively stringent *stop-loss provisions*, which specify the maximum amount of user fees a patient can be required to pay during a calendar year.

On the production side, most care in Sweden is provided in primary care centres and hospitals that are owned by the county councils and staffed by doctors and nurses who are salaried council employees.[30] Some counties have privately practising doctors, but all of them now must have a contract with the county council in order to be paid. Since the 1990s' reforms, most county councils have implemented some form of purchaser-provider split along lines similar to those used in the United Kingdom. That is, each county council has a "purchaser" (funding agency) that negotiates with providers about what care they are to supply during the budget year and how they are to be paid for it. This arrangement is yet another example of applying the principle of managed care to a publicly funded and organized system.

Unlike the United Kingdom, Sweden has seen great variety in the way the purchaser-provider split has been implemented. In some counties, it has had no real effect: the "contract" between the purchaser and the provider essentially states that the latter (typically a hospital) will continue its current activities in return for a budget similar to last year's. But the effect is significant in other counties, especially the big cities, where some hospitals have been sold to private interests that then negotiate with the county councils about the terms on which they will provide care; in the judgment of some observers, the result has been an increase in system cost effectiveness.[31]

Conclusions: Lessons for Canada?

The approaches to health care reform taken in the countries discussed above contain lessons for Canada that, to some extent, complement those that I identified in discussing the US system.

To health economists, the Dekker-Simmons reform proposals in the Netherlands are particularly intriguing, in much the same way that the Clinton plan was. Both represent relatively sophisticated approaches to the difficult problem of designing a system that efficiently combines two health care system functions: protecting citizens against the worst financial consequences of

30 The evidence from Sweden (OECD 2000) suggests that paying doctors by salary is not conducive to high productivity. Historically, the average number of patients each doctor sees per day has been low by international standards.

31 Harrison and Calltorp (2000) provide an interesting discussion of Sweden's experience with health system reform.

serious illness through insurance *and* providing a cost-effective package of different kinds of health services when patients fall ill.

Complicated designs are, however, difficult to explain to the public and vulnerable to attack by vested interests. It may not be entirely coincidental that both sets of reforms have proved difficult to sell politically. The Clinton plan went down in flames in the United States, and progress in implementing the Dekker-Simmons proposals in the Netherlands has been excruciatingly slow. Thus, one must conclude, with some regret, that neither design provides a good blueprint for concrete medium-term reform proposals for a country such as Canada, where the political obstacles to health reform are as formidable as anywhere.[32]

Both the UK and Swedish cases contain important lessons for Canada's provinces. One is the significance of decentralization and the separation of purchaser and provider roles in systems with a single public insurance plan. The reason this feature should be so important is not immediately obvious. Perhaps people in a large organization acting on behalf of government as the payer for health services have more difficulty representing the interests of the public at large when they are also responsible, as managers and employers, for the welfare of providers at all levels. That is, a centralized system with no purchaser-provider distinction is particularly subject to the danger of producer interests' effecting a "regulatory capture" of the organization. Decentralization, with an arm's-length, contract-based relation between the purchaser and individual providers, may reduce this problem. Moreover, a decentralized system can use regional population-based funding as an instrument for making the allocation of aggregate health resources less open to political interference.

The Swedish debate over the right to choose a family doctor and the hospital in which to have elective surgery confirms the importance of preserving a considerable degree of freedom for patients to choose their providers. Being treated for illness is not an impersonal buyer-seller transaction, so patients highly value the right to have some control over deciding who carries it out. However, the UK experience complements the evidence from the US system that giving people an unrestricted choice of any provider at any time in a fee-for-service system is not an efficient way of respecting this right. A system in which patients agree to be treated by a single regular primary

32 In defence of the health economics profession, it is probably fair to say that the process of working out the type of idealized competitive process that both plans encompass has likely been helpful in suggesting general principles that should come into play for less ambitious reforms. For example, one can recognize elements of the Clinton and Dekker-Simmons blueprints in some of the reforms that have been applied to current US Medicaid and Medicare+Choice plans.

care provider (paid, at least in part, by capitation) but have the right to switch among providers at specified times appears to be preferable.

Finally, the UK experience with fundholding and the evidence that will be generated from giving the GP group practices an increased role as purchasing agents are particularly intriguing. Indeed, the suggestion is that when a universal, publicly funded plan retains patients' right to choose among capitated primary care providers who have a financial interest in arranging cost-effective packages of care for their enrollees, the boundary between a decentralized public monopoly plan and a system of competing managed-care plans becomes indistinct. Thus, one can see the possibility of incorporating certain elements of managed care without going all the way to a system of separate competing plans along the lines of the Dekker-Simmons and Clinton plans.

Alternatively, one can see the capitated fundholding model as a first step on the way to a system of competing plans that would offer patients a considerable degree of choice. For example, if the primary care provider that receives the public subsidy is a group practice, some plans might choose to pay its individual doctors at least partially through fee for service, and patients who prefer to be treated by doctors paid this way could choose such a plan. If fundholding practices were allowed to differ along these lines, the step to allowing the ones with more desirable features to charge their clients a premium (as the Clinton plan envisaged) is not a long one.

Proposals for Reform

In this section, I draw on lessons from international experience to advance a set of specific proposals for reforming Canada's system of provincial insurance plans. I offer them as responses to some of the problems that I discussed earlier. My recommendations are, to a large extent, based on approaches that have been used or developed in the countries I discussed in the previous sections, but I have tried to think of modifications to make them practical for use in a Canadian setting.

Tax-Based User Fees

The first and most urgent problem that most participants in the Canadian health care debate perceive is simply that the provincial systems today have too few resources. As I noted earlier, I share the view of those who argue that an equally high priority should be more efficient management of the resources that are already being spent. But I am prepared to accept that, over time,

more resources must be spent on health care, no matter how efficiently we manage them, and even that what is being spent today is less than what the public is willing to pay in order to improve access to high-quality care.

I am reasonably sure, however, that trying to spend enough to provide everything that the public would demand at a zero price is not a viable strategy. Our only options are rationing in some form or requiring patients to pay part of the cost of at least some of the health care they use. Both elementary economic theory and recent experience in Canada and other countries tell us about the difficulties with the rationing alternative, which leaves us with user fees. My first reform proposal, therefore, is to introduce a system of modest patient cost sharing. To counter, at least partially, the most important objection against user fees in the Canadian debate — namely, that they are especially burdensome for the poor — I also favour making the fees more progressive by linking them with the tax system.

The User-Fee Debate in International Perspective

Although some countries, such as the United Kingdom and Canada, make publicly insured services available to patients at no out-of-pocket charge, most require some degree of patient cost sharing for most services. Sweden has relatively high user fees for physician and hospital services, and so does the US Medicare plan. Other countries with publicly funded systems in which user charges are considerable include France and Japan.

In Canada, the public debate about user fees evokes stronger emotions than almost any other social policy issue. Opponents typically base their position on two assertions: user fees "don't work" in reducing health services use and the aggregate cost of care, and they have a disproportionately heavy impact on people with low incomes.

As previously discussed, the most-cited evidence on the effectiveness of user fees in reducing use is from the Rand study in the United States (see Newhouse and the Insurance Group 1993). It shows that health services use by people covered by a plan with a substantial deductible was 30 to 35 percent lower than that by people who faced no user fees. Other plans in which patients paid a smaller percentage of their total health care costs (up to a prespecified maximum) involved smaller but still quite significant reductions in use. This evidence is inconsistent with the view that user fees "don't work" in reducing the aggregate cost of care.

An argument sometimes heard in Canada is that the results of the Rand study would not generalize to a situation in which all patients in the system had to pay user charges. In the Rand study, the falloff in any given doctor's

income as a result of the induced utilization reduction would have been small since only a few of each doctor's patients were likely to be enrolled in the study. In contrast, if all patients had to pay user fees, each physician's income would tend to fall substantially. According to an idea popular among Canadian health economists, doctors would simply undo this effect by exploiting their information advantage over patients to persuade them to maintain their use of physician services even though it now would cost them more to do so. Readers familiar with the health economics literature will recognize this hypothesis as a variant of the concept of supplier-induced demand, or SID.[33]

Although nothing is wrong with this idea in principle, the empirical evidence in favour of the SID hypothesis is not strong. Moreover, under a system in which limited user fees were accompanied by a change in the way doctors were paid, their incentive to induce demand would no longer be there.

One can find more weight in the argument that user fees could be inequitable in the sense of having a disproportionately heavy impact on the poor. If health services are what economists call a *necessity* (a commodity on which, at any positive price, the rich spend a smaller share of their income than do the poor), then introducing user fees would reduce the welfare of the poor by more than that of the rich. However, user fees could still be efficient in the sense that the money they would generate for government could be more than sufficient to increase transfers to the poor and reduce taxes for those with higher incomes, leaving every income class better off on average.

On balance, the evidence in favour of the effectiveness of user fees in reducing health care use, without causing significant detrimental health effects, seems sufficient to justify a modest level of fees. The case becomes even stronger if they can be introduced in a way that reduces the burden they impose on people with low incomes. This criterion could be met by designing a tax-based user fee system of the type advocated by Aba, Goodman, and Mintz (2002) or one of the similar schemes suggested by others.

Under such a fee system, patients would not have to pay anything when they receive an insured service, but a record would be kept of each patient's use and the user charges added to his or her provincial income tax liability. The program design could specify the amount of the charges in any number of ways, but it would generally be a fixed percentage of the total cost of the

33 The SID concept has played a major role in the theoretical and empirical literature on health economics worldwide since the 1970s. One of the most frequently cited articles on the subject is by the Canadian economist Robert Evans (1974). His views on user fees (see Barer, Evans, and Stoddart 1979; and Evans 1984) have had a profound influence on the Canadian debate about health care policy over the years.

services the individual used during a year, subject to some kind of upper limit (a stop-loss provision, as is used in Sweden).

A simple way of moderating the burden on people with low incomes would be to compute the maximum amount for which an individual was liable as a percentage of his or her taxable income. With such a provision, those at the bottom end of the income scale — those whose taxable income was zero — would be entirely exempt; those with low but positive taxable income would still be protected to some extent.[34]

Those who oppose user fees in general recognize that a tax-based system of this kind would remove some of the standard arguments against them. Because the charges would be collected at income tax time, rather than when the services were received (at the "point of service"), no one would be denied access to care because of the lack of cash. Moreover, the system could be designed to reduce the burden on people with low incomes.

Other Points

Opponents of user fees raise some other objections, however. First, they claim that, even if point-of-service user fees would be somewhat effective in reducing use, tax-based ones might fail to do so precisely because they would remove the need to have cash at the time of deciding to seek treatment. To my knowledge, we have little or no empirical evidence on this point. It seems reasonable to expect that predicting the effectiveness of tax-based user fees on the basis of, for example, the Rand study would tend to produce overly optimistic numbers. The economic theory of rational behaviour suggests that, no matter what the timing of payment, the responses to any user fees should be similar, but the extent to which this conclusion applies in this case remains an open question.[35]

Another argument against tax-based user fees is that they would be expensive to administer, in part because of the need for a system of cost accounting and recordkeeping by service providers (hospitals, physician practices, and perhaps pharmacies) that is more comprehensive than currently exists.

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34 In the Swedish system, the stop-loss provision is expressed as a fixed sum of money, but special provisions exempt from user fees individuals at the bottom end of the income scale (such as social assistance recipients).

35 A similar question arises with respect to the tax treatment of savings. Even though using a registered retirement savings plan system — under which tax relief is provided through treating savings as a deduction from taxable income — should have effects similar to non-taxation of the returns from savings, the former may have a relatively greater effect because the tax relief comes when the savings decision is made, rather than later. (See Bernheim 2002.)

Clearly, tax-based user fees would involve considerable administrative costs. However, increasingly sophisticated technology (such as smart cards) could contribute to reducing them. Moreover, improvements to current methods of estimating the cost of individual health services and of treating different kinds of diseases would be highly desirable in themselves. In general, the lack of good cost data has been a significant obstacle to improved resource allocation in health care. An important side benefit of better cost information might be increased public awareness of the cost of health care, strengthening the political will to implement better cost control and more effective resource use in the sector generally.[36]

A further question deserves brief mention. If a tax-based user fee system were introduced, should private insurers be allowed to offer plans that would cover the fees for which taxpayers would be liable? A considerable literature argues against this alternative on the grounds that supplementary insurance (such as the medigap plans that cover the user fees payable under US Medicare) indirectly impose an additional burden on the taxpayer. The reasoning is that because such plans effectively eliminate the incentive effects of the user fees, they increase service use. But if the user fees in the public plan were specified as only a fraction of any incremental spending, part of the cost of this induced increase in use would be shifted to the public purse. The premium on a supplementary plan would reflect only the patient's share of the total cost under the public plan; it would not cover the government's share of the incremental spending. Thus, the supplementary private plans would have the indirect effect of raising the cost of the public insurance plan. (Equivalently, the public plan would subsidize the cost of the supplementary private plans.) Thus, a case exists for making supplementary insurance plans subject to a special premium tax to offset this effect.[37]

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36 I am indebted to Alison O'Brien for suggesting this idea. My own view in the past has been that, even though I favoured limited user charges, they were so controversial in Canada that it was better to work toward introducing other kinds of reform instead (such as capitation in primary care). O'Brien points out that many of the supply-side reform ideas have been around for a long time, with little in the way of serious implementation efforts. With opinion polls now suggesting that Canadians are willing to give user fees serious consideration, a national debate on them may, indirectly, get the public to pay more attention to other methods of cost control as well.

37 For a formal discussion of the efficiency properties of supplementary insurance, see, for example, Blomqvist and Johansson (1997), and references cited there.

The case is somewhat different if the user fees in the public plan take the form of a deductible under which patients pay 100 percent of the cost of their care up to a ceiling. Even in this case, however, the existence of private supplementary insurance is likely to raise the cost of the public plan somewhat. The reason is that coverage by a private supplementary plan will, at least to some extent, raise the percentage of patients whose utilization exceeds the deductible under the public plan.

Regionalization and a Purchaser-Provider Split

On balance, I favour a system of modest tax-based user fees, but I do not believe that, by themselves, they would have a very large effect in terms of reducing service use or producing a more cost-effective pattern of care. In the terminology of the health economics literature, tax-based user fees are tools that attempt to influence use by affecting incentives on the *demand side* of the market (that is, the incentives to which *patients* are subject). The evidence suggests that demand-side measures are much more likely to be effective if they are combined with incentives that affect the decisionmakers on the *supply side*: doctors and those who manage the funding and production of health services. So I now turn to a discussion of what I consider the potentially most important types of supply-side reforms.

A weakness I noted with the current Canadian system is that in certain respects it remains overcentralized. International experience provides a variety of models of managing a publicly funded health insurance system in a decentralized manner. The particular model that I believe the provinces should carefully consider is that of population-based funding and a purchaser-provider split along the lines that have been tried in countries such as the United Kingdom and Sweden.

Although Canadian commentators have already actively discussed decentralization and population-based funding,[38] moves in this direction are more likely to yield good payoffs, in the form of increased system efficiency, if they are combined with a purchaser-provider split and a funding model that, at least in principle, involves competition for contracts by providers, especially in the major urban areas (where most of Canada's population lives). Introducing reforms to facilitate moving toward a system governed along these lines is my second proposal.

Population-Based Funding

The basic idea behind population-based funding is simply that the allocation of aggregate health care resources across population groups should closely reflect each group's relative need for health care. Although such a principle may seem obvious, the existing distributions of health resources in many countries do not seem to correspond closely to it, for a number of reasons. First, in countries with publicly funded systems that are managed in a centralized

38 For an interesting discussion of the decentralization issue in Canada, see Lomas et al. (1997) and earlier articles in the same series.

fashion, political factors may exert an important influence on the way health care funds are spent, and the actual allocation of resources may reflect the relative bargaining power of different provider interests more than the distribution of the need for care. Moreover, politically driven funding decisions tend to become inflexible, with historical patterns playing a major role in resource allocation even when the distribution of the need for care changes.

Population-based funding may take many forms. The principle common to all such systems is that the amount of resources allocated to any population group is determined by some kind of automatic *formula* that is intended to reflect that population's need for care. Theoretically, the simplest type of approach would be one in which care needs are simply assumed to be proportional to an area's population, so that each region receives the same amount of resources per capita. In reality, however, the funding formulas actually proposed or used have been more complicated. At a minimum, since care needs tend to vary with sex and age, most formulas give different weights to men and women and to individuals in different age groups. Also proposed have been even more complex approaches reflecting factors such as population density, average socioeconomic status, and so on.

The implementation of population-based funding can take several forms. Under the Dekker-Simmons proposals in the Netherlands and under the Clinton plan in the United States, it would result from the formulas used to compute the government subsidy to each competing insurance plan. By construction, the subsidy system would allocate funds across the population groups enrolled in each plan in accordance with each group's estimated need for care.

Under the versions of population-based funding used or proposed in countries such as Sweden and the United Kingdom, the relevant populations are those of each region. That is, in a system that has only a single monopoly insurance plan, formula-based funding allocates funds across regional populations, not across competing plans. This is the version that would be relevant in Canada as long as our system continues to be based on each resident of a province being covered by the same insurance plan.

Working out the precise details of a funding formula would obviously be a complicated process, with strong resistance coming from regions that would receive less money under the formula than they do under the existing system. For the initial stages of the scheme, the designers would have to find some means of agreeing on how to account for the cost of services that the population of a given region has traditionally received from institutions (such as tertiary care hospitals) in another region. In the long run, however, resource allocation based on an automatic formula rather than on direct negotiations between the government and service providers should make the

system function more smoothly. In the Canadian context, the use of a formula would make the allocation of aggregate provincial funding less politically sensitive, allowing managers to concentrate on the problem of how to use resources more efficiently rather than on strategies to get a bigger share of the total budget.

As in Sweden and as proposed under the new version of the purchaser-provider split that the Blair government is implementing in the United Kingdom, the funds to be allocated under a population-based funding scheme should cover all insured health services. That is, the system should apply not only to hospital services but also to physician services and pharmaceuticals. As discussed earlier (see especially footnote 26), this principle is important because it would give the regional authorities an incentive to balance the different forms of care and other inputs (hospitals services, outpatient physician services, and so on) so as to best control costs and promote the health of the regional population.

A significant practical issue with respect to implementing a system of population-based funding is the timing and speed of change. Clearly, a large-scale, once-and-for-all reallocation of funds would be highly disruptive — and probably infeasible politically. A nonspecific proposal to "move toward" population-based funding, with no specific time lines, would not likely be effective either. The trick for policymakers would be to come up with an intermediate alternative: a timetable for the gradual reallocation of current funding in order to reach the formula-based targets by a specified deadline.

The Purchaser-Provider Split

One can imagine a regional system of population-based funding without a purchaser-provider split. Under such a scheme, all regional funds would be allocated to a single institution responsible for managing the system that supplies health services and drugs.[39]

In contrast, the essential idea behind a purchaser-provider split is that, in general, a good approach is to separate decisions about what services the system should produce from the management of the institutions that produce them. That is, it is useful to create a clear distinction between the role of regional managers as representatives of the interests of the consumers of health

39 The Swedish system was organized this way before the recent reforms. The county council provided essentially all hospital and outpatient care through its own hospitals and primary care centres, and through doctors who were salaried county council employees. Note that, under this system, each county council functioned essentially like a regional monopoly HMO.

care in their region and the role of the managers of the institutions (hospitals and physician practices) that produce the health care the population needs. In part, this separation could be accomplished by explicit contracts between the regional funding agency (the purchaser or "prudent buyer") and the provider institutions regarding what kinds of care would be provided, in what quantities, and on what terms. The details of how individual providers or organizations are to meet the terms of the contract would be left to the providers themselves.[40]

One might argue that a form of purchaser-provider split already exists in Canada, since hospitals are not formally owned by the provincial governments but are independently managed, privately owned institutions, and most doctors operate private practices. Thus, the formal changes necessary to implement an explicit purchaser-provider split here would not be very dramatic. In those provinces where hospital funding has already been decentralized, the reformed system would differ from existing arrangements only in two significant ways. First, funding of existing hospitals by regional authorities would be based on more explicit contracts than apply under the present system. Second, the funding of physician services would be brought into the same envelope as hospital services, and physicians would be paid under contracts with the regional authorities.

Although most contracts would be between regional funding authorities and local (within-region) providers, funding agencies should have the right to contract for certain kinds of care with providers outside the region if they can offer care on better terms than the local ones.

From an institutional point of view, an important question is to whom the purchasers would be accountable. If they were bureaucrats appointed by the government (as they are in the UK system), they would be accountable to the higher-level bureaucrats in the ministry of health. If they were elected (as they are in the Swedish county councils), they would be accountable to the citizens who voted them in. To me, the idea of elected purchasers has considerable appeal, and it could be relatively easily applied in the Canadian context, especially if the *Canada Health Act* were modified to give provincial governments more leeway to experiment with alternative forms of health system governance without interference by the federal government.

40 The superior efficiency of a system that separates the purchaser and the provider roles is consistent with the trend in US managed care that I noted earlier in this lecture. HMOs, which have no such separation, have been losing market share to other forms of managed-care insurance in which contracts are negotiated between the plan and separately managed provider firms.

Capitation in Primary Care

Earlier, I argued that lack of competition in our provincial health insurance plans may be why the managed-care revolution that has swept the United States over the past two decades and is becoming an increasingly recognizable element in the health system reform movements in a number of European countries has so far not had much of an impact on the Canadian health care system. In particular, the trend toward requiring some form of patient rostering and toward paying doctors at least in part through salary or capitation in systems with managed care has not been in evidence in Canada, where most doctors continue to be paid through conventional fee for service.

In contrast, capitation is an important element in the UK primary care system (where it has been used since the founding of the NHS in 1948) and increasingly in US managed-care plans, in some counties in Sweden since that country's family doctor reform, and in the Netherlands as sickness funds begin to contract with physicians as envisaged under the Dekker-Simmons plan. My third proposal for Canadian reform is to move toward more reliance on capitation in paying physicians, particularly primary care ones. In addition, we should consider the UK idea of broadening the capitation system (via a fundholding system) to encompass part of the cost of other health production inputs, such as pharmaceuticals and some hospital services.

A fee-for-service system encourages doctors to be efficient in the sense of producing a large volume of services, but it does not provide an incentive to keep a large number of patients healthy. A system of capitation does. Under such a system, a doctor's monthly income essentially depends on the number of patients on his or her list, regardless of the volume of services provided to each one. Indeed, capitation indirectly encourages doctors to provide as *few* services per patient as possible, so as to enable them to increase the size of their practices. For this reason, many analysts argue that the best system combines elements of both capitation and fee for service. I am sympathetic to the idea of such a mixed ("blended") system.

The health-promotion incentive inherent in complete or partial capitation is clearly desirable, but the system has the disadvantage of requiring a rostering scheme. Program design can, however, reduce the significance of this restriction in various ways. First, patients are normally given the right to change doctors at given intervals (say, every six months). Alternatively, in some systems, patients may go to another doctor if they are not happy with the recommendation of the doctor on whose list they appear, but only if they pay a fee.[41]

41 The idea of using an element of capitation in paying for primary care is supported in several recent Canadian reports on health system reform — for example, the Mazankowski...

In addition to advocating capitation, I believe there is a strong case for combining it with some form of fundholding, especially if provincial insurance plans are expanded so as to provide for some form of universal coverage of the cost of pharmaceuticals. In the United Kingdom, as well as in some US managed-care plans, the capitation principle has been expanded to include a system of fundholding under which the primary care provider has to pay some portion of the cost of other health care resources that his or her patients use *on that provider's recommendation*. Typically, fundholding systems cover the cost of the pharmaceuticals that primary care providers prescribe, as well as the cost of the services of specialist consultations and certain forms of hospital care that patients use after referral from their primary care giver.[42]

Designing a system of capitation and fundholding for use in Canada would obviously require a great deal of care. A potentially serious issue is cream skimming, to which UK planners paid considerable attention in the context of their fundholding experiment.[43] The problem could be addressed through a two-pronged approach. One would simply be regulation: enacting rules that prohibit the practice, and devoting resources to enforcing them. The other would be reducing doctors' incentive to cream skim, in part by constructing formulas to adjust the capitation amount payable for a given patient according to factors expected to influence his or her need for care (the obvious ones, such as age and sex, as well as any previous history of illness, the presence of certain chronic conditions, and so on). Another way to lessen the incentive to cream skim is to pay doctors through a blended system of both capitation and fee for service.[44] Finally, with fundholding, the incentive

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Note 41 - cont'd.

...report (Alberta 2001) and the Kirby report (Canada 2002). It is also extensively discussed in a comprehensive blueprint for health care reform in Canada by Jérôme-Forget and Forget (1998) and favoured in a position paper recently issued by the Ontario College of Family Physicians (1999). Ottawa has also funded (through the Health Transition Fund) several pilot projects involving capitation. However, although a change to capitation for *primary care doctors* is widely supported, it is not clear that the support extends to the idea of patient rostering, which is an essential component of a capitation system.

42 In the Canadian context, fundholding contracts with primary care providers would be a natural way for regional authorities to respond to the incentive they would have to combine the services of primary-care physicians with those of specialists and hospitals, as well as pharmaceuticals, in the most cost-effective way possible, given that the cost of all these inputs into the health production process would come out of their regional budget.

43 An important paper on this issue is Matsagannis and Glennerster (1994). A great deal has also been written about it by Dutch health economists, in the context of the Dekker-Simmons reforms. See, for example, van de Ven and van Vliet (1995); a recent survey by van de Ven and Ellis (2000) contains many additional references.

44 As noted above, such a system might be appropriate in any case because it would also reduce the incentive for doctors to undertreat patients in a system of pure capitation.

could be lessened by requiring doctors to pay only a relatively small share of the costs of the prescription drugs and various kinds of specialist and hospital services included in the scheme.

Although the task of designing these rules may seem daunting, planners would have a great deal of knowledge and literature to draw on, not only from the UK and Dutch experience, but also from US managed-care plans.

Choice among Alternative Insurance Plans

Few countries now offer citizens as little choice about the form of their health insurance coverage as Canada does. In US Medicare, Americans ages 65 and over can choose among several versions of the plan, including managed-care options. They can also opt to supplement their Medicare coverage with private medigap insurance. Britons and Swedes can buy private health insurance as an addition to (or substitute for) their public plan coverage. Dutch citizens whose income exceeds a given level can choose among a great variety of private insurance plans; under one of the Dekker-Simmons reforms, everyone would have a right to choose from any of many competing regulated plans. In Canada, in contrast, the only choice available relates to those services and inputs (for example, dental care and pharmaceuticals) that the public plan does not cover. For the core items that the public plan does cover (physician and hospital services), it is effectively illegal for insurers in Canada to offer alternative private coverage.

In principle, I favour a system of universal coverage in which all citizens are automatically covered by a basic public plan but those who so desire may substitute some form of approved private coverage and receive some form of tax or premium rebate from the province — in other words, a system similar to what the US and Dutch health care systems would look like if the Clinton and Dekker-Simmons reforms had been completely implemented.)

A wholesale move to such a system would, however, require elaborate safeguards against problems such as cream skimming and adverse selection, and it would be very controversial. For that reason, my fourth reform proposal is somewhat more modest: offering citizens a choice between two alternative kinds of public coverage — one essentially corresponding to the status quo, the other a managed-care plan with patient rostering and payment of doctors, at least in part, on the basis of capitation.

Capitation and Rostering as an Option

From the viewpoint of both patients and doctors, a system of capitation and rostering would imply substantial changes from the current pattern of health

services use and practice. For some patients, the restrictions inherent in rostering and in requiring referrals for the use of specialist services might be considered major disadvantages. For doctors, a capitation system would mean important changes in the incentives they face when deciding how to treat their patients, and fundholding would affect what drugs they chose to prescribe and which patients to refer to specialists. A proposal to introduce these changes on a compulsory, universal basis would be highly controversial.

An important challenge, therefore, is to find ways in which Canada could try out reforms of this type gradually, allowing patients and doctors some leeway on whether or not to buy in. One way of doing so would be to offer a rostering/capitation plan as a *voluntary* option to the status quo. Patients could choose *either* to continue under the present system or to accept the restrictions inherent in a rostering/capitation system. Similarly, doctors could decide between continuing to be paid on the basis of fee for service or to accept a system of capitation and fundholding for some or all of their patients.

Needless to say, designing a workable system that would allow for this kind of voluntary process would be technically challenging. Regional authorities would have to contract with doctors practising under both payment methods, and some way would have to be found to make the choices of patients and doctors mutually consistent. For example, if most doctors in a small community chose a rostering/capitation system, most patients in that locality could not choose to be treated by a doctor in a traditional fee-for-service practice, at least in the short run.[45] Thus, it might not be possible to guarantee that the same degree of effective choice would exist in every community. In large urban areas with many doctors, however, competition among them would likely ensure that patients would have a choice.

Other things being equal, most patients might prefer to continue to be covered under the traditional fee-for-service plan since it would have fewer restrictions. However, the principal argument in favour of a plan with rostering and capitation is, of course, that it would tend to give rise to a more cost-effective pattern of care. That is, the expectation would be that, for given groups of patients, the expected per capita cost to the public sector plan would be lower than under the traditional system. Given this differential, it seems reasonable for patients to have some form of financial incentive to choose a rostering/capitation plan. Such an incentive could be integrated with the tax system; for example, people who chose a rostering/capitation

45 In the long run, competition would presumably bring about at least some adjustment to patients' preferences. Doctors preferring to practise under, for example, a fee-for-service arrangement would move to communities that had a significant demand for this form of practice. And some doctors would switch their form of practice in response to their patients' preferences.

plan could be given a small tax credit. Alternatively, where a compulsory premium partially funds the health care system, as in Alberta, this premium could be set at a higher level for residents who chose the traditional plan. Also, the incentive could be designed to reflect the different expected cost savings to the public sector caused by factors such as an individual patient's age and sex.[46]

Two-Tiered Health Care

To my mind, allowing health care reform to occur through voluntary choice and competition between different types of institutional arrangements has considerable appeal. No one would be *forced* to change, and reform would take place only to the extent that the new arrangements prove themselves superior. Assuming that the federal government chose to play a less intrusive role in health policy formation than it currently does, the decision of whether or not to experiment with voluntary choice could also be left up to the electorate of each province.

However, some Canadians would certainly oppose my suggestions. Allowing people to choose between different institutional arrangements can be interpreted as implicitly allowing the existence of two or more kinds of insurance plans. If consumers made their choice subject to some type of financial incentive (as they would in the face of a tax credit or a compulsory premium that differed between plans), opponents would argue that such incentives were more important for those with low incomes. Thus, people with low incomes might systematically tend to choose the less expensive plan. In the Canadian debate, this situation would certainly be interpreted by some as two-tiered health care.

In my opinion, this objection is misguided in that it fails to distinguish between two separate objectives: providing low-income Canadians with a decent standard of consumption in general and with high-quality health care in particular. The fact that, when given a choice, low-income Canadians might prefer the less expensive of two plans (in order to spend more of their

46 The idea of allowing consumers a degree of choice among alternative types of publicly funded insurance, with some incentive to choose the ones less costly to the government, could, in principle, be applied to the idea of introducing a system of tax-based user fees as well. That is, if a provincial government introduced a system of user fees along the lines discussed earlier in this section, it could also offer consumers the option of belonging to a plan with no user fees, as at present, and paying a health insurance premium higher than the one for those opting for the plan with tax-based user fees. Again, the premium could be made age-specific in recognition of the fact that the expected cost increase associated with opting for no user fees might vary with age.

limited income on other things) can obviously be taken as an argument in favour of providing more resources in general to this group. It does not seem logical to me, however, to take it as an argument against allowing a less expensive plan to exist.

Pharmacare

Among the countries with universal publicly funded health care insurance, Canada is highly unusual in not having universal coverage against the cost of pharmaceuticals. Even in the United States, the idea of expanding the Medicare plan to provide drug coverage is one of the top items on the health policy agenda. For Canada, the case for some type of pharmacare initiative (perhaps through revising the *Canada Health Act*) to ensure universal drug coverage is compelling.[47]

In recent years, expenditure on pharmaceuticals has grown at an even faster rate than other kinds of health spending; in Canada, it now accounts for a share of total health care costs larger than that of all physician services. Although many Canadians have coverage against drug costs through public or private plans, the burden of having to pay for pharmaceuticals out of their own pocket can be substantial for uninsured individuals with serious illness. The incremental cost to the public sector of removing this gap in the social safety net need not be very large; because of the public sector plans that already exist for special population groups (the elderly and social assistance recipients) and, in some provinces, for the population as a whole, the public sector already pays for about 50 percent of the total cost of prescription drugs.

The Arguments in Favour

The desire to improve the comprehensiveness of Canada's publicly provided insurance coverage is the main argument for having some type of universal pharmacare plan. There are some additional arguments as well.

First, under current rules, pharmaceuticals that patients use *when they are hospitalized* are, in fact, covered under provincial insurance. For patients who have no out-of-hospital drug coverage, this situation can introduce a perverse incentive. One suspects that some doctors are tempted to delay sending patients home from hospital to protect them from having to pay for expensive drugs themselves once they have been discharged. Although this

47 For a detailed survey of issues related to a possible pharmacare initiative in Canada, see Blomqvist and Xu (2001).

problem may not occur frequently, it constitutes an additional argument in favour of a pharmacare plan.

Second, transferring responsibility for paying for most pharmaceuticals to a single provincial plan would save on administrative costs for patients who currently are covered by private insurance and have to keep their receipts and file for reimbursement from their private plans. Under a public plan, pharmacies can submit direct claims more easily.

In addition, existing publicly funded pharmaceutical plans have relatively elaborate sets of rules governing what drugs are covered and specifying the maximum to be paid for given types of drugs. Designing such systems of rules (often referred to as *formularies*), along with continuously evaluating and making decisions about coverage for newly introduced drugs, constitutes an important part of the cost of administering pharmaceutical plans. Consolidating each province's drug coverage into a single public plan would facilitate these tasks and somewhat reduce costs. And it could be done in a way that preserved a degree of flexibility in doctors' and patients' choice of drugs (for example, by offering at least partial coverage for particularly expensive drugs that should be used only in special circumstances).[48]

From an administrative point of view, the simplest way of creating universal pharmacare coverage would be for each province simply to expand the public plan it already has for particular groups to encompass the entire population. These plans are, however, currently funded separately, largely out of general provincial revenue. If provinces continue to move in the direction of delegating authority to regional health authorities, there is a strong case for making these authorities responsible for paying for pharmaceuticals. The case here, like the one for physician services, is based on the idea that it would be desirable for a regional authority to have responsibility for essentially *all* health care costs. One can consider hospital services, physician services, and drugs as separate inputs into a single process: that of producing good health. If major responsibility for this process is delegated to regional authorities, they should be in a position to act on possible tradeoffs, such as the reallocation of resources from inpatient to outpatient surgery, or the substitution of drug treatment for surgery in dealing with some chronic illnesses. With drugs, another important tradeoff is the substitution of less expensive

48 Of course, the saving would be even greater if a single Canada-wide formulary were used. Although adoption of this idea might be ruled out on the grounds that it would be inconsistent with provincial autonomy, some of the cost savings might still be realized if the federal government took the initiative to develop a voluntary "model formulary" that the provinces could modify if they wished.

alternatives (perhaps generics) for more costly drugs, which a system of fundholding could encourage.[49]

One can make a case for creating some consumer choice in the form of drug coverage. For example, Quebec now guarantees universal drug coverage by requiring every citizen *either* to belong to the basic public plan, in which case he or she is charged a premium that is integrated with the income tax (so that those with low enough incomes do not have to pay the premium) or to obtain from a private plan coverage that is at least equivalent. Although Quebec's experience with this mixed plan so far has not been problem free, the principle of preserving a degree of freedom of choice and competition among plans in this way seems attractive.

The Federal Role in Health Care Policy

At the beginning of this lecture, I argued that a serious weakness of Canada's health care system is the divided federal-provincial jurisdiction over health care. Our system of health care funding and services provision would almost certainly function better than it currently does if responsibility were completely transferred to either level of government. Given the reality of Canada's federal system, however, it is reasonably clear that the provinces will, in the foreseeable future, be the level of government that carries the main responsibility. This fact raises the question: what role is there for the federal government in health policy in Canada in the medium-term future?

From a technical viewpoint, the easiest way to solve the problems caused by the divided jurisdiction over health policy would be to abolish the *Canada Health Act* as a federal instrument and replace the CHST with either a transfer of tax points or unconditional federal-provincial revenue transfers. Since support for the basic principles of the act is widespread, it seems likely that most provinces would respond by adopting their own legislation with provisions similar to the act's general tenets and conclude bilateral agreements that would preserve "portability" (that is, guarantee that residents travelling in another province could receive emergency care there). The provinces that so desired could then proceed with health care reform on their own.

I believe that this solution would be more likely than the current deadlock to produce certain beneficial kinds of health system reform in most provinces, but it is not my preferred option. On balance, I favour a continued

49 For a fundholding scheme to be attractive to regional authorities as an incentive device, most patients must be covered by a publicly funded drug insurance plan. If many patients were covered by private plans, savings from more conservative prescription patterns would accrue to them, not to the public funding authorities.

role for a federal health act in requiring all provinces to respect certain fundamental principles in designing their health insurance plans — but with certain important modifications.[50]

Although I consider the "publicly administered" requirement unnecessary and potentially misleading, I favour retaining the requirements that the provincial plans be "comprehensive" and, above all, "universally available on equal terms and conditions." I also support retaining the "portability" condition; it makes eminent sense in a federal system. With respect to the "accessibility" provision, I oppose the current interpretation of it (that is, that it is incompatible with any user fees). On balance, however, I support keeping the phrase in a revised act, essentially as a device to discourage any province from moving to a "catastrophic" plan with a very high degree of patient cost sharing.[51]

The major change that I advocate is taking a different approach to enforcement of the *Canada Health Act*. Most important is separating enforcement from federal-provincial transfers, so that the role of the act would essentially be a persuasive one. Such a change, it seems to me, could do much to reduce friction between the two levels of government. A system with some sort of independent tribunal mandated to rule on allegations that a province was violating the act (and perhaps also to specify penalties) could, for example, be much less divisive than the current system of more or less unilateral interpretation and enforcement by the federal government.

Given that I favour a less prescriptive role for the federal government in health policy, the recommendations for reform that I make in this lecture are essentially intended for the provinces. Clearly, however, the federal government could have an important and constructive role to play in health system reform. For example, Ottawa could enter into negotiations with the provinces to modify the *Canada Health Act* to include a provision dealing with pharmacare. In addition, Health Canada could obviously facilitate the process of provincial health system reform by devoting more resources to promoting research and public debate on alternative approaches to funding

50 In part, I favour retention of the *Canada Health Act* because, although it has been manipulated for political purposes, it is an important national symbol to many Canadians, and it could continue to fulfill that role even if it were interpreted in a more general way. Another reason is that, if carefully formulated, federal restrictions on the provinces might make the latter more able than they otherwise would be to withstand pressure from provider and insurance lobbying groups.

51 Both the "comprehensiveness" and the "accessibility" restrictions can be seen as ways of indirectly discouraging a major funding role for private supplementary insurance. As I hope I have made clear above, I do not favour a mixed system (such as that which has evolved in the context of the US Medicare plan or that exists in France) with substantial user fees in the public plan, and widespread use of private insurance to cover these fees.

and system design. My impression is that Ottawa already has a considerable amount of expertise in this area, but that the confrontational relationship between the federal and provincial governments has limited the extent to which it can contribute to better public understanding of these issues in a scientific and dispassionate way.

Final Thoughts

The set of reforms that I proposed in the preceding section does not constitute what I personally consider the ideal solution to the problem of designing a health insurance and health care system that is both efficient and equitable. My ideal goes much further in the direction of a system such as that envisaged under the Clinton plan in the United States or in the blueprint for the Dekker-Simmons proposals in the Netherlands.

Those plans give private health insurance a much more substantial role than do the reforms I discuss. To my mind, there is nothing wrong with such a role, *provided* the system includes two things:

- a good publicly funded default plan that covers all citizens automatically, unless they choose to opt out; and
- an effective system of regulation and subsidies to reduce the problems of cream skimming and adverse selection.

Provided these conditions are met, I see nothing wrong with allowing people who so desire to purchase alternative privately provided insurance. However, as I noted above, explaining the kinds of regulation and subsidy systems that would be necessary to make a plan like the Clinton plan accomplish its objectives is not easy, and I see no reason to believe that proposals for a plan of this nature would fare any better in Canada than they did in the United States (though they would fail for somewhat different reasons). The proposals I offer are designed so as to have more of a chance of being taken seriously. (They also are constructed to be, at least to some extent, separable. It would be possible to implement some of my reforms even if the whole package is not put in place.)

Much of the opposition to an expanded role for private insurance in Canada is ideologically based. Two types of objections should, however, be taken somewhat seriously. One is that if people who are able and willing could leave the public system and buy private insurance instead, their opting out would reduce the quality of the services the public plan could offer because the most skilled doctors and other health care personnel would move to the private sector. The other is that, indirectly, allowing private

insurance would harm people with low incomes, because taxpayers who had enough income to buy private insurance if they were not satisfied with the quality of the publicly funded default plan would be unwilling to pay for a decent system of health care for the poor.

Superficially, both of these suggestions appear to make sense. However, both seem to me to be based on a questionable assumption about the political process. In particular, they imply that the result of a restriction that is, by itself, inefficient (forcing everyone, rich and poor, to belong to the same health insurance plan) somehow induces those with high incomes to accept through the political process an amount of total real income transfer to the poor that is larger than would result if this inefficient restriction were removed. The real income of the poor in Canada depends not only on the standard of health care they receive but also on how much they pay in taxes and on the transfers that take place through other programs, such as social assistance, employment insurance, education, and so on. Although the standard of *health care* that poor Canadians enjoy is higher than it would be without the requirement that everyone be covered by the same plan, it is not clear that this restriction translates into a higher *overall level of real income transfer* to the poor than would prevail without it. I leave it to the reader to decide how much impact this idea would, however, be likely to have in the Canadian political arena.

Another topic involving the public-private balance that I have not said much about is the role of privately provided health services. Part of the reason for this omission is that it does not seem, in the grand scheme of things, as important an issue in Canada today as the other reforms I have discussed here. Most Canadian health care is, technically, privately produced already. Physician services are privately produced, as are pharmaceuticals and most nursing home services. Even hospital services are, from a legal point of view, produced in the private sector, in the sense that hospitals are private institutions. In order to receive provincial funding, hospitals may not be run for profit — a significant restriction.[52] Although I favour a system in which provinces (or regional authorities, if funding were decentralized) could fund for-profit hospitals as well as nonprofit ones, I do not believe that the way this issue is resolved will make a big difference one way or another.

Finally, we must remember that, in health system design as in other areas of public policy, what constitutes the best solution changes over time. The Canadian system as it functions today may have been a perfectly reasonable one in an era of simpler medical technology, when the amount of

52 Much of the debate about private clinics in Alberta deals with the question of how this restriction should be interpreted.

resources that could be productively used in health care was much smaller than it is today, and medical students could learn about most effective interventions in a relatively short time. (Remember, at one time, most operations were performed by part-time surgeons whose main occupation was cutting people's hair.) With the amount of resources that can be used in health care with today's technology, we must pay more attention to cost control and cost effectiveness. With new technology constantly coming on stream, the importance of such considerations will only become greater. In the end, can we really enforce the rule that all Canadians, rich and poor, must have access to the same range of interventions, even though some would be willing to pay more (in the form of insurance premiums or taxes) to have access to additional ones, while others would prefer a combination of fewer interventions and lower cost?

Nevertheless, although the package of reforms I advocate does not correspond to my ideal design, implementing them could lead to considerable improvement in the efficiency with which the health care system manages resources. The importance of this improvement cannot be overstated. Although more and more Canadians think that the quality of health care offered now must be improved, even maintaining today's standard of care seems to require growth in health expenditure beyond what the provinces are able to sustain, and well in excess of the rate of growth in GDP. In the long run, this situation is not sustainable. Anything that can be done to raise the quality of the system without requiring additional resources is worth looking at seriously. The package I propose would have great potential for doing so.

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